No. 02-5664

(6)

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In The
Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX
VOLUME II, Pages 158 to 384

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Petition For Certiorari Filed August 2, 2002
Certiorari Granted November 4, 2002

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

St. Louis Missouri
September 29, 1999
9:10 a.m.

vs. Cause No. 4:97CR290 (DJS)
4:98CR177 (DJS)

CHARLES SELL,

Defendant,

TRANSCRIPT OF THE EVIDENTIARY HEARING
RE: INVOLUNTARILY PSYCHIATRIC
TREATMENT AND MEDICATION
BEFORE THE HONORABLE TERRY I. ADELMAN
UNITED STATES MAGISTRATE JUDGE

TRANSCRIPT ORDERED BY: Lee T. Lawless

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Transcribed By: Carter Transcription & Reporting Company

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[3] (Opening of the Court 9:10 a.m.)

THE COURT: We are here today based on the Defendant's motion that the Court conduct a judicial

hearing regarding the propriety and advocacy of the involuntary administration of medication and other treatment to Dr. Sell. I granted that motion, and that is the purpose of our hearing here today. In that regard I would like the record to show that, Dr. Sell is here in the courtroom with his attorneys, Mr. Barry Short and Mr. Lee Lawless. Mr. Mark Light. The Government is here represented by Mr. Howard Marcus and Ms. Dorothy McMurtry. Mr. Marcus, Ms. McMurtry, Mr. Lawless, Mr. Short, are you all prepared to proceed on this matter?

MR. SHORT: We are, your Honor.

MR. MARCUS: Yes, your Honor.

THE COURT: All right then. Mr. Marcus the way I read the case is, it is your burden to show the need for, – the involuntary medication and therefore would ask you to proceed.

MR. MARCUS: Yes, your Honor, before we proceed I just wanted to confirm one thing for Mr. Lawless, my understanding, from our conversation yesterday that you would stipulate to their expertise as witnesses. Is that still in effect?

[4] MR. LAWLESS: Yes, that they, – I'd probably would like a copy of their, –

MR. MARCUS: Mr. Short has a copy, –

MR. LAWLESS: Get me one too, to put into the record.

MR. MARCUS: Okay.

MR. LAWLESS: But, we are not going to contest it, – testify his expert witnesses.

MR. MARCUS: Your Honor, at this time I would call Dr. Richart DeMier.

MR. LAWLESS: I'd like to invoke the rule to exclude witnesses.

THE COURT: Okay.

RICHART DEMIER, GOVERNMENT'S WITNESS, SWORN

MR. MARCUS: May I proceed?

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MR. MARCUS:

Q All right, Mr. DeMier I'm going to hand you what has been marked Government's Exhibit 2 which is a, – we would ask you to identify this for us please?

A Yes. That's my Curriculum Vitae, which describes my education and clinical experience.

MR. MARCUS: I would like to offer Government's Exhibit 2 in evidence at this time.

[5] THE COURT: Any objection?

MR. SHORT: No.

THE COURT: May be so admitted. Thank you.

BY MR. MARCUS:

Q All right, Dr. DeMier, what is your occupation?

A I'm a Clinical Psychologist.

Q And, by whom are you employed?

A I'm employed by the U.S. Medical Center for Federal Prisoner's.

Q And how long have you been there?

A I've worked at that institution four or five years.

Q Okay. Dr. DeMier in your capacity, at the Medical Center in Springfield, have you had an opportunity to have contact with Dr. Sell?

A Yes, I have.

Q And what would be your role as to Dr. Sell in the institution?

A I evaluated Dr. Sell when he was admitted for an evaluation of competency, that evaluation occurred between February 24th and March 25th of this year. I have also worked with him since his return to our institution on April 20th of this year, when he was committed for competency restoration treatment.

Q And when he was committed initially and now you have been his attending clinical?

[6] A That's correct.

Q Any you knew that the mental health evaluation was done, was that done with you along with an Intern?

A That's correct.

Q And you did intake interviews?

A Yes.

Q And, in addition to structured things such as that, and psychological testing, have you had contact with him on an everyday basis, or every other day basis?

A During his original evaluation, I had contact with him, probably every business day.

Q Okay.

A Since he's been back for competency restoration treatment, I've had frequent contact with him. Both on his living unit and more formal individual interviews.

Q Now, Dr. DeMier, in addition to this type of contact with him, as the attending clinician, do you also do contacts with the, – medical center staff with Dr. Sell?

A Yes, I do.

Q And would this include psychiatric nurses as well as some of the trained correctional officers?

A That's correct.

Q And what would be the need to do that for?

A During evaluation and treatment of this type, I [7] think it's very important to rely on multiple sources of information. The observations of the correctional officers, who have training and working with our mental health population and the observations of the psychiatric nurses, just provides more information than I might get simply by my own interactions. It's not uncommon that defendants will present differently when they are around their doctor than they do when they around other individuals.

Q Okay, Dr. DeMier, as we indicated earlier, you and an Intern were involved in the original mental health evaluation, would it be correct?

A That's correct.

Q And the intern signed off and you signed off on this also?

A That's right. We authored the report together.

Q And at that time based on your experience and training, you had an expert opinion that he was suffering from a disillusion disorder, and incompetent to stand trial?

A That's correct.

Q And specifically, what type of delusion disorder did you diagnose?

A He was diagnosed with Delusional Disorder Prosecutorial Type.

[8] Q And as such, do you consider him psychotic?

A Yes.

Q And you currently consider him psychotic?

A That's correct.

Q And can you explain to the Court what you mean by psychotic?

A Psychotic means that the person has significant impairments in their contact with reality. In the present case, or with anybody with prosecutorial delusions, they have fixed false beliefs, – beliefs that are not in contact with reality, but that are firmly held even in the face of evidence to the contrary. People with prosecutorial delusions

generally feel that they are being threatened or harassed in some way, and have a tendency to misinterpret neutral stimuli or benign events as something bivalent or threatening are specifically directed at them.

Q And based on your training and experience, in the setting that you are in, what is the appropriate treatment for psychosis?

A I believe that psychosis is best treated with antipsychotic medications.

Q And if Dr. Sell is not provided with medication in your expert opinion, what do you believe will occur?

A I believe that he, – his condition will continue [9] to deteriorate.

Q And are there any long term harms in that?

A There are a couple of very important long term harms in that. Some of these, scientific literature indicates that, delaying treatment for somebody who is sick has two adverse effects. The first is once treatment is initiated it's likely to take a longer time before the person gets better. In other words, the longer they are sick prior to the beginning of treatment, the longer it will take the treatment to work. The second important adverse effect is that some of the literature suggests that, when treatment is delayed, the ultimate outcome, the person's optimal response to treatment maybe diminished.

Q And you believe that to be the case here?

A Yes, I have no reason to believe that his course would be any different.

Q Now, since Dr. Sell's hearing in June of 1999, down at the Medical Center, has there been any change in his behavior situation?

A Yes, there has.

Q And in June of 1999, what was his status in terms of where he was being held at the Medical Center?

A In June 1999, he was housed on an unlocked living unit. Which means he had a single cell, – he had no [10] cell mate, but his cell door was unlocked from around six or six-thirty in the morning until about ten at night. He was able to move around our fairly large institution, go up to the main dining hall for meals, go to the recreation area, – he had a lot of freedom within the boundaries and guidelines of the type of facility we are.

Q And since June of '99, have you seen any deterioration in his mental health?

A Yes, we have.

Q And, – as we stand, he is without medication?

A That's correct. He's without anti-psychotic, –

Q Anti-psychotic, –

A medication.

Q And has he made any comments to you that would be in line with this deterioration?

A He has made numerous comments that indicate that his judgement remains poor and getting even poorer.

Q Can you elaborate on some of the comments that he has made to you?

A Yes. He told me recently that I should be prepared to testify in front of Congress, about my conduct in this case, and the way that, – about my conduct in this case, because he asserted that the way his case is being handled will prevent truths from being revealed about [11] the FBI involvement, – involvement of other law enforcement at the Branch Davidian Complex in Waco, Texas.

Q Has he talked to you about his role concerning the Geneva Convention?

A He stated that, as a member of the Geneva, – because of the Geneva Convention, he should be allowed to practice as a dentist within our facility.

Q Have you had any conversations about Bosnia, and the need for him to go to Bosnia?

A Yes. This probably predated the hearing in June, but when the U.S. Military initially became involved in the Bosnia conflict, Dr. Sell stated that he expected the U.S. Military to come to our facility to secure his release so he could go to Bosnia. When he was told that that was not likely to happen, he expressed some delusional beliefs that his presence in Bosnia was absolutely essential to the safety of our troops, and if he weren't permitted to go that would mean that it, to use his words, – somebody wanted a lot of American boys dead.

Q Now, since the June of '99 conversations, have you had any conversations concerning his fear of what the FBI would do to him if moved to a local facility?

A Yes. He continues to harbor beliefs that if he [12] were moved to a County Jail, the FBI would have him killed.

Q Has he made any comments in terms of how he views the government?

A It was reported by another staff member that he had referred to the Federal Government as the Anti-Christ.

Q Now, specifically in terms of change of behavior, are you familiar with an incident or series of incidents, centering around a female nurse at the medical center?

A Yes, I am.

Q And can you tell me how this began?

A Dr. Sell apparently, or evidently, began to form an inappropriate relationship with a nurse on staff at our facility. He was inappropriately familiar with her, calling her by her first name, making statements that indicated that he believed they had some sort of special relationship, –

Q At, –

A – those statements persisted; even after he was told repeatedly that they weren't appropriate.

Q At some point in time did he confront the nurse, with the fact he thought they had a special relationship?

A He told her, words to the effect that, you know, – [13] "Why don't you think I'm special anymore"?

Q And who directed him to cease and desist in this conduct?

A That particular nurse explained why the conduct was inappropriate and that it wouldn't be tolerated.

Q And did the conduct continue?

A Yes, it did.

Q Ultimately, as a result of this conduct and escalating conduct, was he placed in a lock-down facility?

A He was moved to a more secure unit of our facility, yes.

Q And did he offer any explanation as to why he believed he was moved, or did he make comments to any staff why he was in this more secure scenario?

A I think it's likely that he misinterpreted the reasons for his move, which were initially disciplinary in nature.

Q And has he ever made the statement, "I was messing with the nurse"?

A Yes, he did tell one of our correctional officers that.

Q And did he elaborate on that, as to physical or non-physical contact?

A Yes he did. He said words to the effect that, [14] "I have never touched her, but I would if she asked me to".

Q Did he ever express any feelings towards her?

A He has expressed love towards her.

Q Okay. And when told this wasn't appropriate, what was his response?

A He said, "I can't help it," he made that statement to the nurse himself.

Q Now, has he ever made comments to any staff members concerning smelling the nurse's presence?

A He did report that to staff members.

Q As a result of this conduct, in this institutional setting, what was the nurse's response?

A She wrote a disciplinary report. We call it an incident reports in the Bureau of Prisons, – which basically accused him of being inappropriate, insubordinate and refusing to follow an order, the order being to cease the behavior.

Q In light of conduct and his history, did the nurse feel threatened?

A I believe that she did.

Q And as a result he was moved into this more secure environment?

A That's correct.

Q Can you describe for the Court the secure [15] environment he was moved into after this series of incidents with the nurse?

A He was moved to a unit where he is maintained in a single cell, that is without cell-mates. The cell door is locked continuously. He is allowed to shower every other day. He's allowed out of his cell for recreation, for an hour a day, five times a week. It's a very restrictive setting. Before his cell door can be opened he cuffed, – he is handcuffed through a slot in the door. Doors on that unit, not just for Dr. Sell, – but for anybody on that unit, the door cannot be opened by policy without three staff members on

the unit. He is, – he receives a pat search whenever he leaves his cell.

Q Now, based on his history and in the contact in the series of events with this nurse, were there concerns that he was forming another form of a delusion?

A There are concerns that he was developing a delusion of the erotomania type.

Q And what is that?

A That is a delusion that a person is in love with, with a patient, usually a person of higher status.

Q And given his history and this series of behaviors, in your opinion does this present a risk of danger?

A Yes, especially given his history, and the recent behaviors, we thought that the risk to others was [16] becoming much more immediate.

Q In looking at his history you were familiar with and incident involving Dr. Sell spitting on a magistrate?

A I am familiar with that.

Q And you are familiar with the charges in the pending case?

A Yes, I am.

Q And that would include a plot to murder a Federal Agent as well as a government witness?

A Yes, I am familiar with that.

Q And you are familiar with his history in the other county jails he was held in pending trial in this matter?

A Yes, I understand that his behavior was very disruptive in other settings.

Q So these are all factors that go into your considerations in light of his recent conduct?

A That's correct.

Q Now, you talked again about this incident with the nurse. Does this reflect a general trend in terms of how he's dealing with the staff down there?

A I think it reflects a general gradual deterioration in his clinical condition.

Q And would this be responses that are inappropriate, [17] but are more personal and directed?

A That's right, whereas previously his focus of his delusions have been on larger entities or larger issues, he appears to becoming more focused on a personal basis, he becomes, – his statements and thoughts become directed at this nurse or he told me that I would personally have to appear before Congress. So, his focus, – the focus of his delusional beliefs is becoming more immediate.

Q And this would be changes you perceived since June of 1999?

A That's correct.

Q Now, you noted the poor judgement in the directed and personal actions, do you see any cognitive slippage occurring?

A I think that is all reflected in cognitive slippage.

Q Okay. Given his history which you've eluded to in the series of events that have occurred since June of 1999,

do you have an opinion as to whether Dr. Sell himself is dangerous?

A Yes, I do.

Q And what is that?

A I believe that he is dangerous at this time.

Q And Springfield Medical Center is attempting to [18] deal with this as best they can by extreme restrictive settings?

A Well, I think that we are able to maintain the safety of our staff and of other patients, and of Dr. Sell himself, by keeping him in our most restrictive setting.

Q This is an extreme setting you have him in at this time?

A It's among the most secure settings in the Federal Bureau of Prisons.

Q Now, in terms of his behavior, are there any concerns in terms of a concept called Threat Control Override?

A Yes, there are.

Q Can you explain it to the court please?

A Yes, Threat Control Override, is a fairly recent theory regarding dangerousness in mental illness. For many years there was clinical lore that people that have mental illness are at increased risk of dangerousness. Further research tended to indicate that, that was not the case, that people with mental illness are not at increased risk simply because they have mental illness. In the last several years we've, we as a field, have accomplished more

precise research, and have identified a couple of areas where people do appear to be at [19] increased risk due to their mental illness. One of those areas is a person with a psychotic disorder, that has persecutory features. The term "Threat Control Override," comes from the idea that when a person perceives threats based on their persecutory delusions, their perceived threats, their perceiving to protect themselves may override their behavioral controls. In other words, a person with a persecutory delusion may perceive that he is a danger or at risk, when there is, in fact, no risk, but because of that perception he may act out in a way to defend himself or to strike first, to protect himself from this perceived but, in fact, nonexistent danger.

Q In light of some of the more direct and personal material he has related to you concerning the FBI, do you believe this to be a problem now?

A I think he is an increased risk for behaving in such a manner.

Q When you say increased risk you mean for immediate violence?

A That's correct.

Q Now, in your experience as a clinician have you been involved in the treatment of any patients suffering from delusional disorder?

A I have treated two patients, – I've been involved [20] in the treatment and care of two patients diagnosed with delusional disorder frequency.

Q In delusional disorder, is somewhat of a rare diagnoses?

A Yes, it is fairly infrequent.

Q And it would have been a new diagnosis since 1987?

A That's correct.

Q And, in the two that you have seen, – now as a psychologist, you cannot prescribe medicine, but you were involved in the treatment and you saw how the medicine was prescribed and worked?

A That's correct.

Q What was the treatment that was used in these two gentlemen?

A In both cases the patients were prescribed anti-psychotic medications.

Q And do you recall which medications in these two cases?

A One patient was prescribed Haldol, the other was prescribed Olanzapine.

Q And these are both anti-psychotics?

A Yes, they are.

Q And in the two cases were you able to restore to competency either of the two?

A Yes.

[21] Q And which, – how many of the two?

A One of the patients was restored to competency.

Q And the other patient who was not restored to competency, what was the effect of the medication?

A There was a significant improvement in his clinical condition, even though it remained the opinion of the staff that he had not been restored to competency.

Q All right sir, based upon your training and your experience, would your expert opinion, what would it be concerning the use of anti-psychotic medication as to Dr. Sell?

A I think anti-psychotic medication is clearly indicated, as it is the only treatment that we could reasonably expect to improve his condition.

Q And in your opinion what would be the effect of the anti-psychotic medication on either the issue of violence or the risk of violence or danger?

A If he responds to, – if he has a therapeutic response to medication, I would expect those risks to significantly decrease.

Q And what is your opinion as to the effects in terms of restoring him to competence?

A I believe that he can be restored to competency, as a result of treatment with anti-psychotic medications.

MR. MARCUS: Can you give me just a moment Judge?

[22] THE COURT: Yes.

(Pause)

MR. MARCUS: That's all I have at this time Judge.

THE COURT: Mr. Lawless or Mr. Short whoever is going to do it, whenever, – you can take your time to do it.

MR. SHORT: Good morning, sir.

THE COURT: Good morning.

CROSS EXAMINATION

BY MR. SHORT:

Q Let me ask you, this, Dr. DeMier, since June of 1999, have you been the primary clinician for Dr. Sell?

A Yes, I have.

Q And, since June of 1999, how have you treated him, for the illness that he suffers?

A Since June of 1999, I really have not been able to provide treatment for the illness that he suffers.

Q Other than wanting to give him anti-psychotic medication, what have you done to treat his symptoms?

A I don't believe there is any other effective method of treating the symptoms at this time.

Q Explain to the Court in a little more detail, what is persecutory delusion? Particularly, the type that Dr. Sell suffers.

[23] A A prosecutorial delusion is false belief that's deeply ingrained, the person absolutely believes, the delusions, absolutely believes that what he is thinking is true and accurate. The prosecutorial delusions generally involve themes of being threatened, being harassed, being persecuted or being placed in danger and the person will

hold these beliefs, even in the face of compelling, contradictory evidence. Another important feature of these delusions, is that the persons experience, – the world, – their experience, their environment, is tailored to be consistent with those delusional beliefs. People with this illness will often mis-perceive things, so that they fit into this delusional system. New material is often incorporated into the delusion as time goes on.

Q Would you agree that Dr. Sell specifically has great mistrust for the United States Government?

A Yes, I believe so.

Q And would you agree with me that his distrust probably extends to the Springfield Medical Center?

A I don't know that, but it certainly would be reasonable.

Q Would you say that it is, – that in treatment of persons with the disorder of Dr. Sell's, that as a clinician you would want to gain his trust, or cause him [24] to mistrust you?

A I would prefer to gain his trust.

Q He is put down, – has been put in a more secure environment, you said since June?

A That's correct.

Q And as you later said in your testimony, is as secure as you can get at Springfield Medical Center, correct?

A That's correct.

Q So, because he had an "inappropriate" relationship, which as you described, was nothing other than comments, he has been placed in an environment, similar to one if someone had murdered somebody at Springfield, correct?

A Well, I can't agree with, – the proposition that it was nothing other than comments. I think that we have to attend to the thought patterns, and whether it was, –

Q If he had killed the nurse, he wouldn't have been any worse off than he is now would he?

A Well, I think he would be worse off, he wouldn't be in a different setting.

Q He'd be in the same setting wouldn't he?

A Actually, that may not be true, if he had killed the nurse, he may have been moved to another building.

Q If he'd stayed there, he'd been no worse off?

[25] A He wouldn't have been placed in a different setting.

Q So you have treated Dr. Sell, you being the Springfield Medical Center, as if he had committed the worst of crimes and remained in the Medical Springfield Center, correct?

A I don't, – I don't really think that I can predict what would happen if he had killed a staff member, I've never seen, – seen how we would respond to that.

Q Do you think his treatment now has caused, – strike that. Do you think this secure environment which

he's placed has caused him to trust the government more or trust the government less?

A I don't know that it has had any affect, because of the degree of his distrust for the government from the outset.

Q That certainly wouldn't cause him to trust the Springfield Medical Center more, would it? To be treated just as anybody, – if they'd committed murder had been treated in that facility.

MR. MARCUS: I am going to object to the form of questioning, it's argumentative.

THE COURT: Okay. It will be sustained as to the form.

BY MR. SHORT:

[26] Q He's in lock down?

A He's on a unit called 10E, he's locked down as a colloquial term.

Q It's a euphemism really for a solitary, isn't it, you're locked in period, except for one hour, – what did you say, – how many times does he get out of that cell?

A He's released from the cell, five times a week for an hour of recreation, he's offered a shower every other day; he is released from his cell for medical reasons, interviews, and if he would need an x-ray or dental appointment, or something like that, – of course he would be escorted to that.

Q Do you think that's the situation, – that situation you just described is helping, or harming his mental condition?

A I don't have evidence that it's helping or harming, his mental condition, –

Q It certainly isn't helping is it?

MR. MARCUS: I want to object again, it's argumentative.

THE COURT: I'll allow it, go ahead.

BY MR. SHORT:

Q Would you say that, – being in that situation is helping his mental condition at the moment?

[27] A I think that, keeping him safe from harm, and keeping others safe from harm, is beneficial for him, whether he perceives it as helpful or not.

Q Is that cell cold when it shouldn't be cold?

A Not that I'm aware of.

Q Does it have bugs in it?

A Not that I'm aware of.

Q Is he getting all his legal material as Judge Adelman ordered?

A His legal material is stored on that unit and he can request access to documents within that material. There is by policy, a limit on the amount of, – the amount of legal material that inmates can have, or defendants can have in those particular cells.

Q He doesn't have access to his legal material, without asking for it, does he?

A That's correct.

Q And when he asks for it, it's not necessarily given to him, is it?

A I doubt that it is given to him immediately, I assume that it is provided when he asks for it.

Q But, you don't know one way or the other?

A I know he has complained of not receiving it in a timely manner.

Q And he's right, isn't he?

[28] A I don't have a reason to disbelieve him.

Q Is he even furnished with a writing instrument?

A Yes, he is.

Q How often?

A Supplies, which include pencils are passed on a daily basis.

Q Does he have one in his cell to use anytime he wants to?

A I assume so.

Q But you don't know one way or the other?

A Well, I know he's given the opportunity to have a pencil in his cell, he's swapped out a pencil daily.

Q Now, let's talk about dangerousness a little bit. He was in the, – he did have relative freedom of movement as you described prior to June, did he not?

A That's correct.

Q And, he never caused any danger, to any person before that time, did he?

A No.

Q There were no reports of him being a danger to either staff or other, – other inmates, prior to June, was there?

A No.

Q He never harmed anyone?

A No.

[29] Q Never threatened to harm anyone?

A Not that I'm aware of.

Q And, physically didn't harm this nurse, did he?

A No, he did not.

Q He didn't threatened to harm her, did he?

A No.

Q How many inmates in open population down there, would probably say about a nurse, "If she had welcomed my advances"? I would be more than happy to make advances'. How many people do you think would say that down there, – males? All of them?

A I don't have any basis for estimating how many would respond to that.

Q Do you find that particularly unusual, in that, – jail type setting, with a male, – if you said, "If a nurse would welcome his advances, he might make them"?

A I think it is unusual.

Q But he didn't make them, did he?

A I'm not sure I follow the question.

Q In any event, when is the plan on letting him out of that secure environment?

A My plan is to let him out of the secure environment when his mental state improves to the point that we can do so safely.

Q What you are really saying is, you are not going to [30] let him out if he doesn't take the anti-psychotic medicine?

A I'm not, – given his current mental status, I don't think it would be safe to let him out, and I see anti-psychotic medication as the only effective means to improve his mental state, so that we can give him that freedom.

Q Now, you said that you had experience with two patients, is that correct, – that had a delusional disorder?

A That's correct.

Q And one was treated with Haldol, and one was treated with Olanzapine?

A That's correct.

Q One had restored competence, and one did not have restored competence, but had a recovery of sorts?

A There is significant improvement in his condition, I think it would fall short of what we consider recovery.

Q Which one, – what drug was used on the one that was restored to competence, in your opinion?

A Haldol.

Q Haldol. Is that your recommendation, – I understand that you cannot prescribe it, – but when you, – your recommendation that Dr. Sell be given [31] Haldol?

A I would not recommend one agent over another, I just don't have the, expertise.

Q Are you aware of the side effects of Haldol or Olanzapine?

A Yes, I am.

Q Pretty significant, aren't they?

A I'd be hesitant to say, – I would concede that they are significant, as long as it's recognized that there has to be a cost benefit analysis. There are potentially significant side effects, but there's also potentially, very significant recovery from symptoms.

Q Are both those drugs called neuroleptics?

A Yes.

Q Typical, neuroleptics?

A Haldol is a typical neuroleptic, Olanzapine in is a class of atypical anti-psychotic medications to another class of medication.

Q Have you ever looked at the *PDR, Physicians Desk Reference*, to the precautions and counter indications, dealing with Haldol and Olanzapine?

A Yes, I have looked at those.

Q What's Tardive Dyskinesia, D-Y-S-K-I-N-E-S-I-A?

A Tardive Dyskinesia is a condition, characterized by abnormal motor movements, which are involuntary. It's [32] believed to be caused by long term exposure to certain medications, especially the anti-psychotic medications that are not termed atypical. That is not, – not this new class. But, it's a permanent condition which involves, abnormal motor movements, basically or typically in the face, which can be a – very prominent, the person can't control without sustained attention to it. In other words, the person can control the motor movements for a huge area for a few moments, but can't do so, on an extended basis, –

Q Now, as you said, – I'm sorry, I interrupted you.

A – as soon as they stop trying, the involuntary movements return.

Q As you said it's permanent, it's irreversible?

A That's my understanding.

Q So, the cost benefit there is, if one were to unfortunately undergo this, – side effect, is that one might be rendered competent in your opinion, but have a permanent, tardive dyskinesia?

A If the person were on one of the medications that's been associated with that for a long enough time, and if they were one of the sub-group of people on that medication, that developed the condition, then, yes, that is a risk.

Q Is Neuroleptic Malignant Syndrome, a counter [33] indication for Haldol?

A I don't believe it's a counter indication, it's a very rare side effect, it's significant and should be attended to, but I don't think the mere presence, or the mere fact that, that syndrome exists counter indicates the use of the medication.

Q Is Neuroleptic Malignant Syndrome a potentially fatal symptom, complex?

A Yes, it is.

Q Let me just hand you what's, – I'm going to need to mark the *Physician's Desk Reference, PDR 1999*. Turn to page, – direct you to page 2190, including Haldol, and under the counter indications and after discussing tardive dyskinesia, there is a warning, what is the next section?

A Neuroleptic Malignant Syndrome.

Q Would you agree that there's been a number of cases of branchial pneumonia, fatal, following the use of Haldol? Or do you know?

A I really don't know.

Q What was the other drug, – Olanzapine?

A Olanzapine, O-L-A-N-Z-A-P-I-N-E.

Q I got it here. Neuroleptic Malignant Syndrome, that we just talked about with respect to Haldol, a counter indication of Olanzapine, or do you know?

[34] A I believe that I misunderstood your, – words, – use of the word counter indications previously. And, –

Q Or just a warning, is it a warning?

A I believe it's listed in the, –

Q Counter indication probably is the wrong the term, it's a warning isn't it?

A Yes.

Q Have seizures occurred in people that have taken Olanzapine?

A I don't know.

Q Do you know what all the side effects, or warnings, or problems, and side effects can develop from taking Olanzapine?

A I know the more common ones, I know the ones that our psychiatrist, at our facility, generally discuss with people when taking the form consent. I do not know the exhaustive list of everything that's written for them.

Q So, as the situation exists right now, Dr. Sell is getting no treatment, correct?

A I think that's a fair statement.

Q And, he is going to remain, subject to Judge Adelman's orders on time, he's going to remain in that solitary confinement, until he agrees to take anti-psychotic medicine, right?

[35] A Not necessarily. If his condition improves spontaneously, which I think is very unlikely, but if that happens, – you know, – we're going to make our decisions, about where to keep him, based on his clinical presentation and his behavior, not whether or not he is taking medication. Unfortunately, I think that the medication is

going to be necessary, before we see improvements in his behavior.

Q Do you have a recommendation as to what drug he should be given?

A No, I do not.

Q How many of the anti-psychotic drugs can be given by injection?

A There are several, I don't know the exact number.

Q That's all I have for now.

THE COURT: Any redirect.

MR. MARCUS: No redirect

THE COURT: Okay, you may be excused, Dr. DeMier. Excuse, me, I'm sorry Mr. Lawless, – I apologize, okay. I didn't realize we were going to do this separately, so, go ahead,

MR. LAWLESS: Thank you.

THE COURT: In the past sometimes you've done it all.

MR. LAWLESS: That's all right, thank you.

[36] CROSS EXAMINATION

BY MR. LAWLESS:

Q Dr. DeMier, as I understand it from looking at your Curriculum vitae, you've graduated with a PhD. in May of '94, is that right?

A That's correct.

Q Okay. And since that time, has all of your employment been at the Federal Medical Center?

A Yes, it has.

Q So, you've never been involved in private practice?

A Actually, I do teach a course at a local university, one night a week

Q Okay. Do you see patients privately?

A No, I do not.

Q And so, from '94 to the present, the Federal Medical Center is the only place where you have been practicing your profession, as I understand it?

A That's correct.

Q Okay. Do you have what would kindly be referred to as a caseload there?

A Yes.

Q Okay. And what's your current caseload?

A Currently, my caseload is approximately, fourteen patients.

Q Okay. And are some of those for purposes of [37] competency examinations?

A (No verbal response.)

Q There's not yet been a determination, by a court as to whether or not they are competent, to stand trial?

A Yes, some of them are for court ordered evaluations of competency.

Q Okay. How many of those fourteen?

A At the present time, the number is fairly low, because my duties at the institution have changed somewhat.

Q What are your duties?

A On the mental health evaluation service, we have four psychologists, and a psychiatrist who do mental health evaluations, and most of the time we work with court ordered evaluations. But on a rotating basis, for a six month periods, one person is assigned to evaluate patients who are convicted prisoners sent from other facilities, and at the beginning of September, I started evaluating convicted prisoners, who were sent from other facilities to see whether they need inpatient treatment. So that has significantly reduced the number of forensic examinations that I have done. The cases I have remaining, are in their final stages.

Q Dr. Sell is not a convicted prisoner?

A No, he's not.

[38] Q The convicted prisoners that you're seeing, are they on 10E?

A Some of them are.

Q How many?

A Of the one's that I'm seeing?

Q Yes.

A Two of the three convicted prisoners I am currently seeing are on 10E.

Q Okay. I'm sorry, I misunderstood when you said you saw fourteen, I thought you said that the majority of those now were convicted prisoners, is that not the case?

A The majority of the fourteen, of my current caseload are either competency restoration cases, –

Q How many are those?

A About six.

Q Okay. And Dr. Sell would be one of those?

A That's correct.

Q And the other five, are you treating them with anti-psychotic medication?

A I'm sorry, the other five?

Q Yes, well, Dr. Sell is one of them, the other five?

A I believe all, except for one, are being treated with anti-psychotic medication.

Q All right. What's the current population at the [39] Federal Medical Center?

A It's approximately eleven hundred, I don't have an exact figure.

Q And what is considered the design capacity, for that institution?

A I believe, the design capacity is nine hundred and twenty-five, – I'm pretty confident it's in the nine hundreds, – nine twenty-five is the number that I recall. It may not be accurate.

Q So, there's approximately two hundred over capacity?

A I think that's about right.

Q All right. Now, you said that, – your testimony on direct, was I think that initially, during the competency examination period, you had fairly regular contact with Dr. Sell, what has your contact been since the determination by the Court, that he was not competent?

A It's been less frequent.

Q When was the last time you saw him?

A Last time I interviewed Dr. Sell was, – I believe it was last Thursday, it was approximately a week, to a week and a half ago.

Q And was that interview with Dr. Wilson?

A Yes, it was.

[40] Q Where did that take place?

A That took place in an interview room, on the 10E living unit.

Q What was the purpose of that?

A We both wanted to, –

Q You be, being, – both being, Wilson and yourself?

A Dr. Wilson and my both wanting to interview him, shortly before, this appearance, to be certain that there hadn't been any significant changes in his mental state. I hadn't noted any during the rounds, but I felt it was appropriate to spend a little bit more time with him, so

we're sure of accurate information presented before the Court.

Q Okay. And how long did that session last?

A Approximately an hour.

Q Prior to that session, when was the last time you had seen him?

A I believe that I saw him during unit rounds on Tuesday, of last week.

Q What does unit rounds consist of?

A Basically, that's going door to door, and, – for my patients, just touching base with them, talking briefly, seeing if they have concerns. It also consists of reviewing their record and talking to unit staff, the officers that work on the unit, the psychiatric nurses, [41] to see if there is any evidence of significant changes in their clinical status.

Q How often do you make unit rounds?

A At least weekly, usually two or three times a week.

Q And how long a period of time do you typically devote to unit rounds?

A It varies, based on the number of patients that I have on that unit, –

Q Why don't you give me the range?

A Anywhere from five to, – five minutes, to a half an hour.

Q Per patient, or a total?

A Yes, that's a total.

Q The total time that you would spend making unit rounds would be somewhere between five minutes and half an hour, for all of your patients?

A Yes. And if there was a need to talk to somebody at more length, I would ask the officer to take him out to an interview room. When I go door to door, I don't like to talk at great length about people's symptoms, people's delusional beliefs. I think appropriate place to do that, is an interview room, where they are not going to be overheard by the people who are constantly disruptive.

Q I just want to make sure that I understand what we [42] are talking about as far as your time. Unit rounds consist of you seeing, or reviewing, and making some form of personal contact, with all of your patients?

A On the lock units, yes.

Q Okay. How many patients, in total do you have on the lock units?

A I believe last week I had, I believe I had four. But, that number varies greatly from week to week.

Q Okay. From a high of?

A I've had as many as a dozen or fifteen patients, on the locked units.

Q And as little as?

A There have been times when I have had no patients on the lock units.

Q Okay. When you didn't have any, of course, you wouldn't need to make unit rounds there?

A That's correct.

Q Okay. So, during those times, when you make unit rounds, you say it takes a, – in total somewhere between five and thirty minutes?

A It been a long time since I've had as many as twelve patients on that unit. You asked for a range before, I think with that number of patients, it would probably be closer to forty-five minutes. We are talking about relatively brief contacts with everybody.

[43] Q I agree. Prior to the unit rounds, when was the last time that you had a interview session with Dr. Sell, besides the one that you've testified to, with Dr. Wolfson?

A I can't give you a specific date, it had been a period of a few weeks.

Q Where did that take place?

A I believe that the last interview I had with him, before the one with Dr. Wolfson, occurred on 10E, in the same interview room, one of the two interview rooms.

Q Do you maintain patient files?

A Yes, I do.

Q Did you bring your patient file on Dr. Sell with you here today?

A Yes, I did.

Q Okay. Would that assist you in being able to testify as to when and for what periods of time you interviewed Dr. Sell?

A I don't know that it would give me real specific information. After I see a patient, I generally put a note in

their chart, that talks about the content of the interaction, I don't always specify whether or not I took him out, to an unlocked, – to an interview room.

Q Well, you said you don't like to talk about their delusions, or other things, on locked wards out in the [44] hallway?

A That's correct.

Q Okay. Where is his chart?

A It is, – his chart is in my briefcase.

Q Could you get it for me, please?

THE COURT: You may do so.

(Pause Witness retrieving case file)

MR. LAWLESS: Could I see it?

(Pause)

BY MR. MARCUS:

Q Okay. There are a number of different categories in here. The notes on your interaction with the patient, would be under what?

A Under a ten, – it says, "Progress Notes," about third or fourth it's usually, it should be in reverse chronological order.

Q Let me ask you this, would the incident report concerning this conversation with the female nurse, that you've testified be in here?

A No, that's in a separate file, which I also have.

Q You have that here?

A Yes, I do.

Q Could you get that, please?

THE COURT: You may.

MR. LAWLESS: Thank you.

[45] (Pause)

BY MR. LAWLESS:

Q Okay. As I understand this, then, what he was placed into solitary confinement for was described as the following:

> "Inmate came to nurse's station for aspirin, he wanted to continue talking with this writer. When told, 'I didn't have time,' he stated, "You never have time for me, anymore, I'm not special anymore." He proceeded, to tell this writer, "You just don't realize, what you mean to me". Inmate was given a direct order to leave, that his behavior was out of line. He then stated, "I can't help myself". He has approached this writer in the past, and stated, "Hello, Michelle". He has been reprimanded before for this inappropriate behavior towards this writer."

Is that right?

A That was the, yes, – her description of the incident.

[46] Q Okay, you weren't there?

A No, I wasn't there.

Q Okay. And was there some discipline, – was there some hearing that he had with regard to this?

A No, there was not.

Q All right. If he was a convicted inmate, would he have had a right to a disciplinary hearing?

A Even as a pre-trial defendant, there is a disciplinary process. The clinician, in each case for patients, has the task of determining whether or not they are competent to participate in our internal, – you know, disciplinary process, –

Q Okay.

A – which is much less rigorous, than a corporal procedure, and I gave the opinion that Dr. Sell was not competent to participate in a meaningful manner, in our internal disciplinary process.

Q That he was not competent?

A That's correct.

(Pause – Attorney reviewing document)

BY MR. LAWLESS:

Q Okay, I'm sorry, I have a document here that's dated 7-20-99, –

MR. MARCUS: Can I see that, please, first?

MR. LAWLESS: Sure.

[47] (Pause)

BY MR. LAWLESS:

Q Let me hand you that to you and ask are you familiar with that from having, – your work with Dr. Sell?

A (Witness reviewing document.) I've not seen this before.

Q All right. Is that a document that bears the signature of the Warden?

A Actually, there's a signature of an Associate Warden, who I believe is acting for the Warden that date.

Q Okay. You recognize the signature?

A Yes, I do.

Q Okay. And in there the Warden states that, "As of the twentieth of July, Dr. Sell was competent to proceed in the disciplinary hearing," is that right?

A I'll have to take a moment to read it.

Q Please.

A (Witness reviewing document.) Okay, I've read it.

Q Okay. Does that indicate that as of that date, he was deemed competent to participate in a disciplinary matter?

A I don't think it indicates that.

Q What does it say?

[48] A This relates to a previous incident, –

Q I understand, I understand that, –

A Okay.

Q This was as of June 20th, of this year, – or July 20th, excuse me.

A Uh-huh (positive utterance).

Q Okay, and as of July 20th, the associate Warden or assistant Warden, whatever, was, – signed a document that said what?

A I believe this indicates that he was, –

Q Pardon me, would you, please just read what it says?

MR. MARCUS: Judge, I think he's argumentative, the questions aren't that clear what he's asking.

BY MR. LAWLESS:

Q What does that document say with regard to Dr. Sell's competency to participate in that disciplinary proceeding?

THE COURT: Okay. Let's all calm down, and just answer this question, okay.

THE WITNESS: Okay. "Additionally, a psychologist did not," – do you want me to read the whole thing or just the, –

BY MR. LAWLESS:

[49] Q Whatever relates to Dr. Sell's competency to participate, –

A

> "A psychologist evaluated that your condition, and determined that you are legally responsible for your behavior, and that you are competent to participate in disciplinary proceeding before the Unit Disciplinary Committee."

Q Okay. And that was as of what date?

A This response to his request for an administrative interview, was dated July 20th.

Q Okay. And the incident that you spoke of where he came up to the nurse's station and requested an aspirin, happened on July 24th, is that right?

A I believe that's correct. This incident would have occurred sometime prior to July 20th, I don't know the exact date, I believe it was at least two weeks probably more, previous to this document.

Q Okay. Let me hand you this.

(Pause)

BY MR. LAWLESS:

Q Does that cover that incident?

A Yes, this refers to that incident.

Q And it indicates that it occurred when?

[50] A June 25th.

Q All right. Do you know who would have made the assessment of Dr. Sell's competency as of June 25th?

A I would have.

Q Okay. So, on June 25th you thought he was competent to proceed in that disciplinary hearing?

A Yes, sir. Yes.

Q Okay. And on July 20th you thought he wasn't?

A That's correct.

Q Okay. And then when he's not competent to participate in that, what does he get, as far, as a hearing before he's put into lock down?

A When somebody is deemed not competent, and not responsible for an incident report, the incident report is basically expunged. As you see, a copy of it remains in their file. But there is no further action taken on it. When I made the decision, that I did not believe that he was competent to proceed, then the disciplinary report was no longer an issue and I wrote a clinical order to maintain him on the 10E living unit, on what we call behavioral observation status. So, even though initially he was moved back there as a result of the disciplinary report, after I made the assessment that he wasn't competent to proceed, it was my decision to have him remain on that unit, due to his clinical condition, [51] not for disciplinary reasons.

Q Okay. So you are the person responsible for his being there?

A Yes.

Q All right. Now, during, – Dr. Sell was initially sent to Springfield, back in 1997, is that right?

A That's correct.

Q Okay. And he was there for how long a period of time?

A It would have been a thirty day evaluation, he might have been a little bit longer than that. I don't know the exact dates that he arrived and departed.

Q All right. And during that period of time, did he present any behavioral problems that would have required him to have been put into any, –

A Not that I recall, no.

Q All right. And then he was again seen at Springfield, in the spring of this year?

A That's correct.

Q Okay. And, how long a period of time was that for?

A That was also for a thirty day evaluation, and he was probably there a total of forty days, I'm just estimating.

Q All right. He, –

A He had, – sorry, –

[52] Q That's okay. And during that period of time, was he permitted to remain in the general population?

A Well when the patients are first admitted, they generally are admitted to a locked unit. Then we evaluate them generally the day after they are admitted, because when they come in it is rather late, and as I recall Dr. Sell was on an unlocked unit the day after he arrived.

Q All right. And then when he was sent back for determination as to whether or not he could be restored to competency, when was that?

A He arrived at our facility for the competency restoration commitment on April 20th.

Q April 20th, and he was then sent to lock down in July?

A July 24th.

Q And, during that period of time from April to July 24th, he lived on the open ward?

A That's correct.

Q Okay. Had he been involved in any assaultive behavior?

A No.

Q Had he made any threats, that you are aware of?

A No direct threats.

Q Now, as his treating clinician, have you been [53] involved in any therapy with him since his return to Springfield, in April of this year?

A He was involved in a competency restoration where we use psychological education group that focuses on issues relating to competency, –

Q But was that to educate people on who the judge is and what the lawyer is?

A That's a large part of it.

Q He knew those things, didn't he, he knew, –

A Yes, he did. We'd also focus on such issues such as how effectively help your attorney, how to behave in the courtroom.

Q None of those were issues with him, were they?

A It was my understanding that his behavior in the courtroom was an issue.

Q How's that?

A I understand that he has had a disruptive behavior in the courtroom in the past.

Q What did that consist of?

A I understand that he has spit at a judge.

Q And did that take place in a courtroom?

A I believe it took place in a holding cell.

THE COURT: It took place in a proceeding, Mr. Lawless in all fairness.

MR. LAWLESS: I understand that, Judge.

[54] THE COURT: An initial proceeding.

BY MR. LAWLESS:

Q Do you know whether Dr. Sell was represented by an attorney at that point?

A I don't know the details of the event.

Q Do you know whether or not his attorney was present during that judicial proceeding in the Marshal's lock up?

A I don't recall. I don't know if I've ever known that.

Q Other than the competency restoration group, have you been involved in, or provided anything else in the way of therapy for Dr. Sell since he was returned to Springfield for competency restoration?

A No, I haven't.

Q And when did that competency restoration group conclude?

A The group, met, – it meets on an ongoing basis, on a weekly basis. Dr. Sell was removed from the group, due to his disruptive behaviors within the group.

Q And that consisted of?

A He insisted on discussing his case to the exclusion of the information that was applicable to everybody. And it was my understanding from the group leaders, that he did so in a very controlling and disruptive fashion [55] and he would not respond to directions to refrain from doing so.

Q Now, the nurse that he was supposed to have made these inappropriate comments to, her name is what, Goldberg?

A That's correct.

Q Okay. And Nurse Goldberg was the individual who was originally selected by Dr. Sell, to be his staff representative at his institutional involuntary medication hearing, is that right?

A That is correct.

Q And from reviewing Dr. Sell's file, the reason that he had picked Nurse Goldberg was because he felt she was someone he could get along with and trust?

A I believe that's right.

Q And she then declined to represent him, at that institutional hearing, is that correct? Claimed, – stating that there were some scheduling changes which made it impossible for her to serve in that capacity?

A That's correct.

Q And that institutional hearing took place when?

A June 9th of this year.

Q All right. Now, on l0E is Dr. Sell allowed to have his eyeglasses?

A I don't really know if he is, I don't believe he is [56] allowed to have eyeglasses. I think the regulations prohibit having glasses with metal frames on that unit.

Q Okay. Would he be permitted glasses with plastic frames in that case?

A I believe so.

Q Okay. Does the institution provide him with those so that so that he can see?

A I don't believe that we have.

Q All right. He is fed in his cell?

A That's correct.

Q Okay. They stick a tray in through a slot in the door?

A That's correct.

Q Solid steel door?

A Yes.

Q Okay. Does he have any control over when the lights are on in the cell?

A He can control that to the extent that he asks staff members to turn them on and off.

Q And if they comply with this request then they're turned, – are they on or off for everybody or just for him?

A That could be, the cells are all set up the same way. I'm not sure I understand the question.

Q Okay, if one to turn off the lights in his cell [57] would it turn off the lights in all the adjoining cells or just his cell?

A Just his.

Q Okay. But he has no physical control over when the lights are on or off in his cell?

A That's correct.

Q And I think you already answered, Mr. Short, that his access to legal materials depends upon staff there?

A That's correct.

Q Okay. Is he permitted any books?

A Yes.

Q How many?

A I don't know what the limit is, I believe it's two or three paperback books, which he can swap out on a daily basis.

Q Okay. And then he's permitted a pencil to write with, that they bring around once a day?

A That's correct.

MR. MARCUS: Judge, I'm going to object for a couple of reasons. Number one, it's been asked and answered; number two, I think we're getting outside the scope of the purpose of the hearing today.

THE COURT: Yes, Mr. Lawless maybe we are as to the conditions, although you have your reasons for painting the conditions, and –

[58] MR. LAWLESS: Well Judge, I think, –

THE COURT: I think we have an idea, –

MR. LAWLESS: I think it's more than that. I think that the knowledge with regard to the delusional disorder, the fund of knowledge that's out there in recognized texts, suggest that isolation is contraindicated and that, in fact, what looks to be the most pre-textural of reasons, Dr. Sell has been placed in this isolation as a punitive measure to exacerbate his symptoms, in order to justify his medication.

THE COURT: Okay. Then why don't we get to it, if that's what you are contending.

MR. LAWLESS: All right. All I can do is lay the ground work for it and ask the Court to consider whether that's a correct conclusion or not.

THE COURT: All right. Fine.

MR. LAWLESS: Thank you.

BY MR. LAWLESS:

Q As I understand your testimony, then the only treatment that you feel is appropriate for delusional disorder is medication?

A It's the only treatment that is, – that the literature has shown to be consistently effective.

Q What literature is that?

A A fairly broad base of psychiatric/psychological [59] recent articles.

Q What are those articles? If you have them with you.

A I cannot name, – I don't have the articles with me, and I can't name them, I know I've reviewed several.

Q Okay. Well, let me ask you this, what, – are these matters, with regard to medication, fall more into the realm of psychiatry or psychiatry?

A Psychiatry.

Q All right. In what text would you consider to be authorative, in the area of psychology?

A I believe there is the, *Comprehensive Review of Psychiatry* and we have the name of the book, the authors are Kaplen, K-A-P-L-E-N and Sadock, S-A-D-O-C-K. That's the only psychiatric text that I use regularly. I know our consultant psychiatrist, Dr. Wolfson, has a large volume of psychiatric text that he relies on.

Q Okay. And Kaplen and Sadock, what do they say with regard to the treatment of delusional disorder?

A My recollection is that they say, anti-psychotic medication is the treatment of choice.

Q Any other text that you would recognize as authorative?

A There are other authorative text, I can't name them, I would probably recognize them, that states that [60] I have borrowed them up there.

Q You are familiar with the Affidavit of Dr. Cloninger that was filed on this case, and the studies that were cited in his Affidavit?

A Yes, I am.

Q Okay. And he is a psychiatrist, is he not?

A That's correct.

THE COURT: I am going to take notice of that Affidavit for the purposes of the record, –

MR. LAWLESS: I appreciate that.

THE COURT: – here, Mr. Lawless and –

MR. LAWLESS: I think the original actually was filed, – with, at the hearing in Springfield, I left it there with the hearing officer.

THE COURT: It well could be. You've provided me with a copy plus there's a copy in the file.

MR. LAWLESS: Thank you.

BY MR. LAWLESS:

Q And Dr. Cloninger, in the articles that he cites indicates that treatment by psychotropic medication is contraindicated, is that right?

A In the two sources he cited, I believe he agreed the conclusion that treatment was generally not effective.

Q Drug treatment?

[61] A That's correct.

Q And the *Merc Manual*, you're familiar with that?

A Yes, I am.

Q Volume, I think they are now in sixteenth publication of that. Does that indicate that drug treatment is contraindicated for delusional disorder?

A I don't know what the manual says about delusional disorder.

Q Okay. Do you rely on it?

A No.

Q Never?

A Not in my practice, no.

(Pause)

MR. LAWLESS: Judge, what I have handed the Government, the Witness and the Court, is a report from the Federal Bureau of Prisons Institution Metropolitan Correctional Center, concerning a former client of our office who had executed a release. I don't think that it serves any purposes to bring the patients name up –

THE COURT: No.

MR. LAWLESS: – in this proceeding, and I don't intend to. But, I would suggest that this individual was diagnosed with delusion disorder. And then I would draw the witness' attention to pages 7 and 8 of that, – under the second sentence of "Prognosis [62] here,

> "The opinion of this examiner was that the patient adhered to a system of beliefs which may be termed delusional; individuals who suffer from a delusional disorder often do not respond to mental health intervention."

On page 8, last paragraph that begins at the bottom of the page as noted in the "Prognosis" section;

> "Delusional disorder does not typically respond to pharmacological intervention or psychotherapy".

And I would ask this witness if he is familiar with Daniel Greenstein, the forensic study psychologist, at the MCC in Chicago?

THE WITNESS: Yes, I am familiar with him.

BY MR. LAWLESS:

Q Okay. And Dr. Greenstein's statement, with regard to recognized efficiency of psychotropic medication, is then incorrect?

A I believe that's incorrect.

Q And the date of this report was July 1st of this year?

A Yes.

[63] Q So you disagree?

A Yes, I disagree with this. I didn't disagree with the statement, that delusional disorder is not typically responsive to psychotherapy, obviously I don't know anything about the case.

Q Okay. The two cases that you have referred to, you say one was treated with Haldol, is that correct?

A Yes.

Q In your opinion, that person was restored to competency?

A That's correct.

Q And, what aspects of their mental illness did you, – was it, in your opinion was the Haldol effective in treating?

A This patient had a complex delusional system, of several different things. After his treatment with anti-psychotic medication, he no longer endorsed those delusional beliefs, and, in fact, he appeared deeply embarrassed when they were discussed, – he was embarrassed that he had ever held these beliefs.

Q Did this patient suffer from hallucinations?

A No, I, –

Q Prior to the treatment with medicine?

A I don't believe so, it's difficult to recall all the specifics of the case. I don't believe that he [64] reported any hallucinations or that we saw any evidence of hallucinations, prior to the time that he was diagnosed as a delusional disorder.

Q And, so your opinion, – your testimony then is that, delusions respond to medication?

A Yes, in many cases they do.

Q Now, Dr. Sell has been previously treated with Haldol, unsuccessfully is that true?

A I don't think that's necessarily true.

Q He was treated with Haldol?

A Yes

Q Okay. And that would have been back in the '80(s)?

A That's correct.

Q Okay. And in your opinion, has he been suffering from delusional disorder now for some sixteen, seventeen years? Based on his history?

A It's clear that he's had a psychotic illness that dates back at least that far. I don't know what the course has been, whether or not the symptoms have been continuous or sporadic. I don't really feel comfortable saying he's had the illness in the current form for any period of time that goes back farther than when I met him.

Q But his history was part of what you relied on in making the diagnosis?

[65] A Yes, he clearly had a history of psychotic symptoms, and had been diagnosed with psychotic disorders in the past.

Q All right. And I believe your testimony on direct examination was that, delayed treatment from the onset of the illness, was a factor that would indicate that medications, – treatment by medications would be unsuccessful?

A What I said was, that a delay of treatment from the onset of the illness, is likely, in some cases, to delay the time until a response, and it may diminish the effectiveness of the response. I will not say, just out right that the treatment wouldn't be successful. But, I do think you run risks of the patient not getting better, as quickly or not getting a recovery that is as complete.

Q The patient that you, – that was treated with Haldol, how long from the onset of their mental illness was it till you began their treatment?

A I don't recall specifically.

Q Seventeen years?

A I don't know.

Q Do you know what the patient's age was?

A Late fifties.

Q Late fifties?

[66] A Yes sir.

Q And the other patient that you treated, with Olanzapine?

A Olanzapine.

Q – pine.

A Actually, I did, – was not the treating clinician. I participated in a risk assessment, assessment of dangerousness of this individual.

Q Did they suffer from hallucinations as well delusions?

A No. He suffered exclusively from delusions.

Q And they were not restored to competency?

A That's correct.

Q How long were they treated with this medication?

A I believe they were treated with medication for approximately eight months, during which time there was significant improvement in the clinical condition, even though they weren't restored to competency.

Q The person that was treated with Haldol, how long were they treated?

A I believe about five months.

Q Now, is or is not psychotherapy one of the recommended treatments for delusional disorder?

A I do not believe that's generally recommended for delusional disorder. It will not help a delusional [67] patient out of his delusions. It a feature of the illness, the beliefs are going to be held very firmly, and efforts to dissuade somebody from those beliefs generally results in the person providing treatment being incorporated into the delusional system.

Q Well, I certainly wasn't trying to limit psychotherapy to trying to talk someone out of their delusions. Forgive me if you misunderstood. Can't an individual who suffers from delusional disorder be worked with in order to minimize the adverse affects of their delusions?

A There can be a lot of different focuses of therapy and I apologize for being sloppy in saying, talking him out of a delusion, that's probably not very precise. I think sometimes it might be an appropriate focus of treatment to work with the person on how their beliefs are affecting their ability to function. Typically, that is not successful.

Q That has not been tried in Dr. Sell's case?

A Not on a sustained basis and what you would consider or what anybody would consider a traditional course of psychotherapy.

Q Okay. I think your testimony was the only psychotherapy was this competency restoration group?

A That's right, I had more of a psycho-educational [68] focus which did not, – in the group they did not, – they did not, focus on people's individual cases, their charges, their false beliefs, it's move psycho-educational.

Q At the present time, there is no plan on your part to release Dr. Sell from 10E?

A I have no specific time line, my, – I hope to release him as soon as his condition permits, it's much easier to work with somebody when they are not in such a restrictive environment.

Q And as I understand, Dr. Sell makes some statements that you feel are inappropriate and you send him to 10E?

A I think that kind of misses the reason that he went to 10E. It wasn't necessarily for the inappropriate statements he made, it was due to concerns about changes in his thought process, that would put him at risk to others. I believe the comments reflected significant deterioration in his clinical state.

Q Would it be unreasonable for someone in Dr. Sell's position to view his being put into 10E as punishment for the statements he made to the nurse?

A No, it's not unusual.

Q Nor unreasonable under the circumstances, is it?

A I don't think it's accurate, but it is probably reasonable from his perspective.

[69] Q Did you discuss With him the reasons for his being placed on 10E?

A Yes, I did.

Q What did you tell him?

A I told him that staff had increased concerns about his safety, about safety of staff around him, I expressed to him my beliefs that his condition continued to deteriorate, and would probably worsen over time without treatments. And, I told him that I wasn't going to try to talk him into taking anti-psychotic medications, even though he was free to say, "I'd like to start that," but of course, I was aware that this proceeding was pending, and, – you know, for that reason I didn't try to apply, I didn't try to persuade him as much as I might other individuals who need the medication. There's a process, a legal process involved here that I didn't want to disrupt or try to get out of.

Q Was there any attempt on your part to suggest that there might be a gradual restoration of institutional rights, based on behavior on his part?

A Yes, I have talked of that.

Q Okay. And, he's been locked down now, this is the end of September, lock down took place the end of July, so – we've got August, –

A A little over two months.

[70] Q Two months. Has there been any assaultive behavior on his part during those two months?

A No, there hasn't.

Q Okay. Has there been any inappropriate comments that he's made towards staff during those two months?

A Yes, there has.

Q And what were those?

A After the incident with the nurse, he was discussing that incident with a correctional officer, who noted in the medical record, that Dr. Sell said that he loved that nurse, and that is also when he made the statement to the effect that, he has not touched her but he would if, –

Q Okay, that was shortly after the incident, as I understand it, –

A I believe it was about a week or so, after the incident.

Q Has there been, – that was him discussing, – within 10E itself, has there been anything about his behavior that's been inappropriate?

A I don't recall any behaviors that have been inappropriate since he has been on 10E.

Q So, what does he have to do, to get out of there?

MR. MARCUS: Judge, I am going to object that this is not a function of this hearing, getting him in [71] or out of 10E, this is a decision they made for their own safety.

THE COURT: Okay. Mr. Lawless at this point, I am tempted to sustain the objection, only because the record is efficiently made, if you have something else you need to do, you may do it at, I must ask you –

MR. LAWLESS: I have a real question about this additional claim of dangerousness, as it impacts on

the justification under the cases for the involuntary administration of medication.

THE COURT: You may explore that, although you pretty well gotten into it, if you have something else you want to do about it, I just ask you to do it, okay.

BY MR. LAWLESS:

Q Has Dr. Sell been the subject of any assaults while he's been on 10E?

A No, not that I'm aware of.

Q Okay. He hasn't assaulted anybody?

A No. Due to the nature of the unit, he would not have an opportunity to assault anybody.

Q Are you telling me there haven't been any assaults on prisoners in 10E since he's been there?

A I wasn't finished with my statement yet. There would be no opportunity for him to assault anybody in an effective way. Basically, the prisoners are let out of [72] their cells in handcuffs, with staff present and, – but the very nature of the restrictive unit goes a long way to prevent assaults. I'm not saying that no assaults have ever occurred on that unit.

Q Have there been assaults since he's been there?

A I'm not aware of any assaults on staff since he's been there, I do believe there have been assaults between patients when they've been out on the recreation yard.

Q All right. So with out a recreation yard he can be out there with other individuals?

A Yes.

Q Okay. And he hasn't been involved in any assaults against any other individuals out there?

A Not that I'm aware of, no.

Q Are you aware of his ever been convicted for any assaultive behavior?

A I'm not aware of any such convictions.

MR. LAWLESS: All right. Can I have a moment?

THE COURT: Sure. Certainly.

(Pause)

MR. LAWLESS: I don't have anything else at this time, your Honor.

THE COURT: Mr. Lawless, I didn't agree, – [73] obviously I'm, –

MR. LAWLESS: I didn't feel that way. like that.

THE COURT: – you had something to do, you do it, okay.

MR. LAWLESS: Thank you.

THE COURT: Mr. Marcus.

MR. MARCUS: I have no redirect.

THE COURT: Dr. DeMier, thank you very much. You may be excused.

WITNESS: You're welcome, your Honor.

THE COURT: You may call your next witness. I'll take that back, why don't we take about three, – five minute recess.

(Temporary Recess From 10:50 p.m. Until 11:05 p.m.)

THE COURT: Mr. Marcus, you may proceed.

MR. MARCUS: Your Honor, at this time the Government would call Dr. James K. Wolfson.

JAMES K. WOLFSON, GOVERNMENT'S WITNESS, SWORN

DIRECT EXAMINATION

BY MR. MARCUS:

Q Sir, for the record can you state your name please?

A Yes. James K. Wolfson, M.D.

Q And Mr. Wolfson, where do you currently work?

A I'm at the U.S. Medical Center for Federal [74] Prisoners in Springfield, Missouri.

Q And what is your current position there?

A I'm a staff psychiatrist, I'm the only psychiatrist who is on the forensic service along with other psychologists colleges.

Q All right. Dr. Wolfson, I'm going to hand what has been marked Government's Exhibit 3, and ask you to identify this for us please?

A This is my Curriculum Vitae.

MR. MARCUS: Your Honor, at this time I'd offer Government's Exhibit 3 into evidence.

MR. SHORT: I have no objection.

THE COURT: It be so admitted. Thank you Mr. Marcus.

Q All right. Dr. Wolfson, as staff psychologist at the Medical Center in Springfield, had you been involved in the treatment of Dr. Sell?

A Yes, I have.

Q And, would it be fair to characterize your role in his treatment as a consultant?

A Yes, it would be.

Q And, one of the issues you are involved in consulting, would be the potential use of medication for him?

A Yes. That is how I'm connected to everyone of the [75] competence restoration cases we receive, committed under 18 USC 41:42(D), either and attending or as a consultant.

Q And, in your capacity as a consultant, were you, – you've had an opportunity to have various interactions with him?

A I have.

Q And, how would you characterize the nature as your interaction with Dr. Sell?

A Well, I have been present on a more limited number of times than has his attending clinician, Dr. DeMier. I was present for initial interview, on his return to our facility, present on a handful of other occasions, saw him just a two days ago now, and was also present at his due process hearing. Probably, something under six hours

of total contact time in terms of intensive interview time. And then during the times that he was out among the population in the prison area, I would encounter him on a casual basis, multiple times a week.

Q All right. Dr. Wolfson, based upon your contacts with him, your review of the records and the diagnosis provided by Dr. Demier, in your opinion would you consider Dr. Sell to be psychotic?

A Yes.

Q And based on your experience, what is the [76] appropriate treatment for psychotics?

A Anti-psychotic medication is the appropriate treatment to relieve psychotic symptoms.

Q Now, Dr. DeMier diagnosed Dr. Sell as suffering. from delusional disorder, you are familiar with that diagnosis?

A Yes, yes I am.

Q And, the diagnosis of delusional disorder, that is a relatively recent label, – or diagnosis?

A It's a recent premeditation of an older concept.

Q In 1987, that was added as the label, delusional disorder?

A Correct.

Q Now, in your experience and your training, have you seen people that have come in with particular diagnosis and end up with another?

A Yes, I have.

Q And, in Dr. Sell's case, what is his opinion on his diagnosis?

A I am deferring, a definitive opinion on his diagnosis, it's clearly psychotic. The diagnosis of delusional disorder is a plausible one, there are some potential features to his history, plus, a level of caution I prefer to adopt overall, that leads me in a situation where I am not comfortable, excluding the [77] notion of schizophrenia, as an alternate explanation to his symptoms.

Q And, whether it's schizophrenia, or delusional disorder, these are merely labels that have been applied to a set of symptoms?

A Yes. They're labels, they should have utility when they are applied correctly and cautiously, but they are labels.

Q And, based your experience and your training would it be fair to say that both schizophrenia and delusional disorder can respond to anti-psychotic medication?

A Certainly, and that one of the reasons why there doesn't need to be a rush to diagnosis, prior to selecting appropriate therapy.

Q And, it wouldn't be unusual in terms of behavior to see a continue, where a diagnosis might change or a label may change?

A Diagnosis change primarily as more information about a patient accumulates, as more time and contact and more longitudinal course occurs. Every now and again, the diagnostics team also gets changed around, so that we have to revise what labels, most usefully, to characterize that patient's problems.

Q But, in Dr. Sell's case no matter what the labels applied, you still believe that he is psychotic?

[78] A Yes, that's, – that part is unequivocal.

Q Now, you indicated that you believe the appropriate course of conduct to treat someone who would be psychotic, whether they were schizophrenic or suffer from delusional disorder, would be the anti-psychotic medication. And, what is your opinion as to what will happen to Dr. Sell, if he is not treated?

A I anticipate that he will deteriorate. He's likely with the one diagnosis of schizophrenia, more likely with the other diagnosis of delusional disorder, which is less likely, to reach a spontaneous remission. I anticipate that he will have further loss of function, his liberties have already been severely curtailed, if we do not address his illness, that's likely to get worse.

Q And, would you believe, – view this, deterioration of conduct as something that will be ongoing and continue unless treated?

A Yes, I do.

Q And any response that the medical center has instituted, in terms of how they house him would be in response to his deteriorating condition?

A That has been, – yes, that's been related to his current circumstances.

Q Now, since June of 1999, have you seen specific [79] changes in his conduct?

A I've seen some and heard about more.

Q Okay, so your opinion would be based on you've seen and what you've heard, in review of your records?

A Correct.

Q And, are you familiar with his conduct becoming more directed and personal?

A Yes.

Q And, what does that mean?

A Well, one of the concerns, and what played a role in him leaving general population status, and moving to locked unit, had to do with apparently developing a relationship or connection to one of the nurses. That left us with significant concern.

Q And, what were your significant concerns?

A Well, he was, speaking as if he was attached to her, I don't remember the precise phraseology, but something, – that he'd been overly friendly with, – he'd been discouraged as any prisoner would be, had not responded to being discouraged from her, and after an episode where he was finally brought out of general population, I believe he made a remark to one of the correctional officers, "I didn't touch her, I would have if she'd asked me," I don't remember the rest of it verbatim.

[80] Q Did he indicate that he was in love with this nurse, and could not help his behavior?

A He did, which is somewhat of an uncertainty for someone in that position, that's indicative of his degree of impairment.

Q Okay. Would it also be indicative of his cognitive slippage, and his inability to function, or know reality?

A I think so. I mean it certainly stands as a start contrast, to his career and most of his life history. I don't think, a person, a responsible physician, now in this position doing these things, at a place like this.

Q When he was initially confronted with his behavior, did he discontinue it immediately?

A No.

Q Now, in your experience, when other prisoners have made inappropriate comments and they have been noted, what is the response?

A Typically, they comply, particularly if they can understand the adverse consequences on their housing situation. We occasionally meet some people who are stubborn and take longer to do that. But, the idea of an intelligent man, being unable or unwilling to see the writing on the wall, continuing until something like this happens, that's a sign of deterioration.

[81] Q Now, in light of his history, either mental health history or history of conduct, and the new conduct concerning the nurse, did it raise any type of heightened worriedness (sic) or concerns on your behalf?

A It did, and I have less in the way of specific information that I would like to have in this particular setting about his prior contact, but it was my impression that there had been problems with a tendency to get fixated on a particular topics, to be tenaciously embroiled in them, other than correspondence to members of the Dental Board, issues with office employees, again I don't

have as many facts as I might liked to have to outline this. But, it seems to be a recurrent theme, it's a recurrent problem rather than an anomalous, one time transit issue, that's my impression.

Q And based on this did you note there to be any immediate risk?

A Immediate risk is tough to qualify, but if they have a fellow who isn't or won't modify his behavior, that's talking about being in love with one of the nursing staff, yes, we can't leave that person out in a position where they can get themselves into further trouble or cause difficulty, for staff members or –

Q Did Dr. Wolfson, did the nurse consider this a threat or danger to her?

[82] A My understanding is that she did.

Q And, does this raise issues of erotomania or delusions of erotomania?

A Well, yes, and that's particularly significant since that, it's thought it was independent subtype, but that is a phenomena seen in delusional disorder, that would be consistent that diagnosis, and if that is indeed what was happening, then it could presented as a very severe problem and very difficult to do anything about once it gets entrenched, if action isn't taken early.

Q When you say difficult, difficult for who?

A Difficult to modify what Dr. Sell would be thinking and difficult to modify what he would do.

Q Given his history and given this conduct that occurred in the light of the psychiatric history and the

information that you have, do you perceive Dr. Sell, in your opinion to be dangerous?

A Broadly defined, yes.

Q And, he sits now, he is in a very restrictive, – the most restrictive set of circumstances?

A Just about, yes.

Q And, that is a result of this perceived danger?

A Correct.

Q Okay. Now based on your expert opinion, and your [83] experience, and your training, what do you think the affects or what is your opinion as to the effects of anti-psychotic medication concerning Dr. Sell's dangerousness?

A I anticipate that it will alleviate it, or reduce it to make it more commandable (sic) to additional interventions such as psychotherapy or behavioral interventions.

Q So, you feel it would be necessary to go through medication first and psychotherapy later?

A I think the medication is a foundation, to whatever form of therapy happens after that. Without it, one cannot anticipate success or meaningful benefit from other therapy interventions. So it may not be sufficient, but is necessary.

Q Now, let me ask you about your prior use of anti-psychotic medication. In the past have you used anti-psychotic medication to treat psychotic patients?

A Yes, I have.

Q And, approximately how many patients have you been involved in the treatment of with anti-psychotic medication?

A Hundreds, my best guess, I really don't recall, somewhere between one and two-thousand.

Q And, in the one and two-thousand you've treated [84] with anti-psychotic medication, have you seen positive results?

A Oh, yes.

Q And, would it be predominantly, in most cases there is an improvement?

A Yes. That's both the conventional wisdom and the research literature, and it's been my own experience.

Q And, as a psychiatrist you are aware that there are some potential unpleasant side effects of the anti-psychotic medication?

A Yes, there are for most medications that are used in any medical specialty and that's true with this.

Q Can you identify any of the unpleasant side effects, that I'm going to categorize those as one set as opposed to a dangerous side effects?

A The most predominant, or conspicuous problem which lies with what are called the high potency conventional anti-psychotic medications, relate to changes in movement and motor function. It can involve a peculiar type of stiffness which may relate to general body posture or may involve spasm of particular muscles in the body, which some has been treatable. And may also involve

peculiar type of restless sensation, sometimes a sensation of slow movement overall, analogous of it to have seen in Parkinson's disease. For that reason, [85] symptoms are subject Pseudo-Parkinsonism.

Q And, are these effects treatable in the institution?

A Oh, yes.

Q Are there any other unpleasant side effects that you have encountered, or read about?

A Well, some individuals will find the medications sedating, there's a continuum of degree of sedation, with different agents. Obviously, our goal is to get patients back so they can defend their cases, and having them sleeping in the courtroom is not the desirable goal, so I tend to chose medications that do that less.

Q Would it be fair to say that, most of the unpleasant side effects can be dealt with by the institution, by either other medical treatments or other medicines?

A Sure. Occasionally there is patient who will have to chose which is worse, some anxious of illness or the side effects, and that's an analysis that almost always favors treatment. There are occasional patients that can tolerate symptoms so that there is a choice that he can actually make about it. But, for the majority of patients, there really is only one sensible choice. But, most patients don't have to expect problematic side effects as the cost of having their illness treated and [86] having control of their own thoughts and minds.

Q Now, in addition to unpleasant side effects, there are also some serious side effects, would that be correct?

A That is correct.

Q And wouldn't it be neuroleptic malignant syndrome?

A Indeed.

Q And, between the thousand and two thousand patients, which you have personally treated with anti-psychotics, have you ever seen this occurring?

A I've seen it, but not in my own patients. None of the patients I have treated are prescribed this type of medication and have developed this.

Q And, in the course of your experience as a psychiatrist, in a, – you have been involved in many large mental health facilities?

A Yes, I have.

Q Many occasions in which, perhaps you weren't involved in the administration of anti-psychotics, but other doctors have?

A Yes.

Q And this would be into the thousands?

A I'm sure.

Q And, how many times have you seen occasions of neuroleptic malignant syndrome?

[87] A During the time I was at Barnes, and Malcolm Bliss and Jewish, and Children's, and The University of Washington in Seattle, Harvard and the University hospital there, U. & M., and then my current employment, I have known of two cases of neuroleptic malignant syndrome

being present in any of those hospitals, at the time, – it's the kind of thing that news spreads from the staff because it is important, it's also interesting. And it's roughly consistent with the, – estimates vary as to it's actual frequency, but a reasonable guess as to it's incidents is something like one in ten thousand cases.

Q Now, based on your opinion, and a cost benefit analysis, and other pertinent, – not a cost benefit analysis, but in terms of risk analysis, do you feel the risk of the continuing illness is greater than they risk of him receiving this medicine and developing this type of scenario?

A No. No question about it. That's why the more typical cases, treating patients voluntarily rather than having to take the decision making process out of their hands like we are doing here.

Q Now, as the consulting psychologist, you would be involved in the actual medication, deciding what's appropriate, and what would be best for him?

[88] A That's correct.

Q And, just in general from a lot of the literature concerning treating the delusional disorder, there's a, – Pimozide is considered a very workable medication?

A It's in the literature, yes.

MR. SHORT: I didn't hear what you said, I didn't hear the drug?

MR. MARCUS: Pimozide, P-I-M-O-S-I-D-E.

MR. SHORT: Thank you.

BY MR. MARCUS:

Q That's been noted in, various studies in the papers?

A That notion is in literature, yes.

Q And, – but in your experience you would prefer more of an atypical, anti-psychotic?

A I'm not certain of that, it was last reported severe characteristics compared to the conventional anti-psychotic medications rarely would be borne out. And there's no theoretical basis for expecting it to be better. The newer drugs have substantial advantages, that I think would probably outweigh any special nature that Pimozide might have, compared to the other older drugs.

Q Pimozide is just been, – it's been discussed quite a bit though, in literature?

[89] A Yes, it has. For this and a couple of other unusual conditions, perhaps somehow being different, but not different to the extent that you are referring to.

Q Sure. But as we noted, atypical anti-psychotics might be appropriate?

A In general, they are preferred in most situations. They generally have a more benign side effect profile, and they also have improved effectiveness for aging patients who failed to respond to conventional treatment, which is not an issue here. There hasn't been much conventional treatment, I've seen perhaps two patients who did better on the old drugs than on the newer drugs, but by and large they are preferred.

Q But based upon your training and experience, your expert opinion would be that the atypical anti-psychotics would be more appropriate for Dr. Sell because, they have minimized side effects and they have increased chances of working in terms of his condition?

A Yes, I believe so. I should mention that one potential limitation and that they are available only in oral forms, so I need a cooperative patient taking them. But, if I have that uncooperative patient and I am confident that he is taking medication, not faking his pills out or something like that, I believe they are preferred.

[90] Q Now, let me ask you this, what medications would you propose for Dr. Sell if you were to treat him?

A I prefer not to get pinned down to a single drug, because part of this I hope to actually leave in his hands, to pick among available alternatives, so he can at least have some role in the decision making process. Of the atypical agents, there are two; Quetiapine, – should I spell that for the transcription, – Q-U-E-T-I-A-P-I-N-E, –

MR. SHORT: I'm sorry, can you spell that again please?

THE WITNESS: Quetiapine. Q-U-E-T-I-A-P-I-N-E, sold as the brand name Seroquel, S-E-R-O-Q-U-E-L. And, another medication, Olanzapine, O-L-A-N-Z-A-P-I-N-E, which is sold as Zyprexa, Z-Y-P-R-E-X-A, and those are the, – I think the two of the three, for atypical agents, those are the two that make the most sense. There is another one that they are hoping to have in a few months, that on paper looks very promising as well called Ziprazodone, Z-I-P-R-A-Z-O-D-O-N-E. As usual, there's experiment in Europe well before it's introduction here. So that

can be considered to, if shows up in time, but those are the ones that make the most sense, be most likely to have a benign side effect so profile.

[91] BY MR. MARCUS:

Q All right, Dr. Wolfson, is your expert opinion that this medication would render him less violent or less dangerous?

A I think by addressing his illness, it should also seek to reduce whatever portion of dangerousness might be related directly to the illness, and by improving his cognitive abilities overall, might even be helpful for dangerousness or orneriness, if there is any from any other source.

Q And, you believe these atypical drug, are best suited for him?

A I believe so.

Q Okay. Dr. Wolfson, are you familiar, at least from the records, from Dr. Sells prior use of Haldol?

A I am.

Q And, that would have been in the '80(s)?

A 1984, is the year, I'm thinking, but that's incorrect, it's 1982.

Q And, how successful was the Haldol, from the records in terms of Dr. Sell's usage of it?

A Well, he was able to be discharged from the hospital, what happened after that I guess is a matter of conjecture, but it would certainly appear that it worked

acutely, to the extent one could tell from the [92] records more than a decade later.

Q So, in other words he took the Haldol, allowed him to get gate passes, get discharged, go back to work?

A Yes.

Q And, do the records indicate he was able to tolerate Haldol?

A The records mention a, – one dystonic, reaction, that's the type of muscle spasm I mentioned, it was coped with by a reduction in medication dose, and I do not recall seeing any other mention of problems tolerating the medication. Now, Mr. Sell, I'm sorry, Dr. Sell has told me that he had all types of problems with it, I don't know if that's a post talk contrite statement on his part, but if he had been and if it happened during the hospital, I anticipate that would have been mentioned here, – been mentioned in the record. It would led to further modification in his regimen.

Q Okay. Now, can you tell me how many patients have you treated that have been diagnosed with the delusional disorder?

A I have treated three patients outside of a legal setting, and I have treated four patients, one of them on two separate episodes, – two separate competence restoration commitments. So, four patients, five times [93] in my current setting,

Q And, of the group of three, and the second group of four, how many did you treat with anti-psychotic medication?

A All of them.

Q And, what was, – what were the results with the use of the anti-psychotic medication?

A All benefited clinically. Naturally, the three long term clinic patients I had during residency were not involved in legal entanglements at that point, so there wasn't the additional issue of competence to proceed with a legal case. But, all three of those patients did well, didn't need to be hospitalized, rather returned to their homes, – one returned to employment, the other two hadn't been employed already for many years. Of the four that had, the four patients that had come through the medical center, – I believe there are probably more – but there were only four whose names I could chase down with the limited time I had. Of those two cases, that were defendants were assigned to my own caseload, I was their attending and wrote the report. One of those was the fellow who has come back a second time, I restored him successfully to competency once, and have just about succeeded the second time. The other case that was mine that did not [94] successfully restore to competence, he nonetheless benefited substantially, clinically, and I went by, – he is back at our facility on another practitioners caseload, and I stopped by to see him on Monday, and he has improved enough that his release from custody if currently being planned. There are two other patients, was probably like another, who were attended to by different practitioners whom I treated, both of them were restored to competence to proceed. So, small numbers, but I guess from that we calculated 80% success rate for successful restorations on a five treatment facility.

Q Okay. Dr. Wolfson, based on your experience and your expert opinion be that you feel that you have a good chance at restoring Dr. Sell, if you are given the opportunity to medicate him?

A I believe I do.

Q Do you believe that it would be appropriate medicine to withhold anti-psychotics from a psychotic?

A No, that's not appropriate. In a sense that betrays what we're all about.

Q Now, the Physicians Desk Reference lists a series of medications ranging from Tylenol to anti-psychotic medications, and in there, there are some detailed lists of potential side effects and consequences, are you [95] aware of the *PDR*?

A Yes.

Q And what is your opinion, in terms of the *PDR* in terms of being a valid treatise, – or a valid source of information for a psychiatrist?

A Well, it depends on what contents it is being used in as an authority. The *PDR* is a convenient compendium of legal information produced by the drug companies that produce and pedal the medications. In as such it may have flaws, that relate to their commercial interests, and certainly has flaws that relate to their liability concerns. So it's a convenient source of information about common side effects, dosage forms on common medications but, it's not comprehensive about any truly important subject, and includes a great deal of information that's quite limited utility. If one wants actual reasonably, useful information

about a medication, there are other sources of information that are much better.

Q Dr. Wolfson, you had reviewed some articles concerning the use of anti-psychotic medication, including the use on Delusional Disorders, would that be the case before coming here?

A Yes.

Q I am going to hand you what has been marked as [96] Governments Exhibit 1, –

MR. MARCUS: Mr. Short, you've got a copy of that material.

MR. SHORT: Would that be the same?

MR. MARCUS: Same as (1).

BY MR. MARCUS:

Q Would that appear to be the material you've reviewed?

A (Witness reviewing document.) Yes, it's just like the copy I have.

Q Okay. And based on your review of the literature, what appears to be the trend and treatment of anti-psychotics, – or delusional disorder with anti-psychotics?

A Well, this is quite interesting, because there is a conventional wisdom that patients with delusional disorder respond less to medication, but I have my own serious doubts with, – based on my own experience. The literature mirrors that experience. It shows favorable results in many cases. Most of these are small series of case reports,

but they show good outcome generally, and a few cases the outcome is characterized as excellent.

Q Have you reviewed the Affidavit of Dr. Cloninger?

A I have.

[97] Q And in there, Dr. Cloninger draws some conclusions, and one would be Number 9, saying,

> "Although, neuroleptics are often recommended by physicians for control of agitation, or psychotic symptoms, there are no data to justify this as a benefit to patients with delusional disorder".

Would you agree with this?

A I would most strongly disagree with him.

Q And if we can go to Number 14, in there it says,

> "This would not constitute an adequate trial of the medication in a patient with schizophrenia, but neither does it provide any basis to think he would be an exception to the rule that neuroleptics are not beneficial in delusional disorders".

Now, neuroleptics are the same as anti-psychotics?

A That's correct.

Q Is there such a rule?

A No, there is no such rule.

Q And would you disagree with this statement?

A I disagree with the statement, and I would further criticize it a proceeding statement. Number 8 and 9 as [98] follows, – to go from this one paper, –

> "naturalistic studies not showing a more favorable end outcome between two groups of patients, does not lead to conclusion that there is no evidence that neuroleptics are beneficial for patients with delusional disorders."

What this should have said would be, –

> "There are no large scale double bind, – double blind, placebo control studies providing effectiveness with delusional disorder".

That's the type of scientific information we like to accumulate. It's most likely that impractical to accumulate such information, in such a fashion, for this illness because it's hard to assemble a large series of patients. And the role of paranoid patients in a double blind study is something that I think would be also a bit of an accomplishment. If any of us ever succeeds in doing it, I'm sure we will be well celebrated for it. But that's not the only kind of data that can be. And there is anecdotal data, there is these case report series, including one method analysis, and statistical [99] combination of prior studies, and also on top of it on two differential it's reasonable to consider relief of psychotic symptoms be a beneficial thing.

Q Now, in this particular Affidavit, in paragraph 5 and paragraph 6, he cites to, one a textbook of psychology, or psychiatry, and the other to a study, – I'm probably not going to pronounce it right, – be referred to as Dr., –

A I should find out how you pronounce this.

Q Opjordsmoen and Dr. Retterstol?

A Yes. Well, Dr. Retterstol, is a, – one of the senior people in the field, and I presume that the other doctors, a

colleague of his, – I can pronounce Retterstol's name, but not the other.

Q And, have you reviewed that document?

A Yes, I have.

Q And what is your opinion, as to that document's validity?

A There's no problem with this paper, there's a problem in the way the paper's been applied to today's question.

Q Okay. Can you elaborate for the Court, please?

A Well, what this study sought to do, – there is a long series of studies that Retterstol's has carried out with the population of patients with schizophrenia and [100] other psychotic disorders. And in that, he's tried to categorize their long term course which relates to response to treatment, but is not simultaneous. It is not completely coincident with that question because, not all these patients were treated the same way, and the substantial portion of this cohort of patients were followed prior to the development of anti-psychotic medications in the late '50(s) and early 1960(s). And, the expected question, if delusional disorder responded to medications, as well as schizophrenia, would be that you see higher functioning in patients with delusional disorder who were followed and treated in the years after introduction of the medications. These medications then before, as has been seen with schizophrenia, But, that is making a few assumptions that Dr. Opjordsmoen and Dr. Retterstol are not willing to make and on the last page they pose, – may I just go ahead and quote it?

Q Please.

A

"Another explanation might be that there are more problems with compliance in delusional disorder, than in schizophrenia. Chronic patients are usually very sensitive to all side effects of drugs. And [101] most reports on the effect of neuroleptic and delusional disorder are still anecdotal. Drug treatment in this disorder therefore still seems to be terra incognita. Controlled drug trials are strongly needed. It also remains to be demonstrated if the affect of Pimozide is specific."

These are world renowned experts in this condition, they are unwilling to be dogmatic about the question of treatment response and they recognize one potential, – potentially very important explanation for the discrepancy in long term course, which is that of the patients with paranoia, with delusional disorder, maybe less willing to stay on medication, particularly in rural Sweden, a long way, – a long distance away for doctors, over a period of decades.

Q So it would, be fair to say, – if you're not compliant, – you're not taking your medicine, – you don't get better?

A It's hard to assess the benefit of medication if its still in the bottle and not in the person.

Q You know, Dr. Wolfson, as we get to the bottom of the Affidavit, Dr. Cloninger proposes, –

[102] "According in my opinion, the treatment of Dr. Sell should be limited to basic support and voluntary symptomatic treatment".

In paragraph 19,

"This would include a safe supportive menu, with access to exercise, and reading material".

And it goes on talking about using anti-depressants. Do you believe, in your expert opinion, this would be effective in treating his psychotic disease?

A No, this is an insufficient proposal. If we were having this conversation in 1935, that would be the best I would be able to offer him. But, this is unsupported, perhaps even irresponsible, to advance that as an adequate response, – as an adequate way to address Dr. Sell's difficulties.

Q Thank you. Do you have Government's 1 there?

A Yes.

MR. MARCUS: At this time I would offer Government's Exhibit 1 into evidence.

MR. LAWLESS: Tell me, – I'd like this opportunity to voir dire the witness, if you are talking about these papers, because they don't seem to view what the diagnosis is.

[103] MR. MARCUS: At this point in time, don't have anymore questions, – I mean if –

THE COURT: Government's 1 is a –

MR. MARCUS: This is a of series of papers –

THE COURT: Okay. That's the papers you showed me, okay. Fine. Do you have anymore questions?'

MR. MARCUS: No I don't.

THE COURT: Okay. Then you may obviously, – I'll withhold ruling on the introduction of this, Mr. Lawless, until after cross examination.

MR. LAWLESS: Thank you.

THE COURT: Okay. Mr. Lawless. I won't make this mistake, a second time.

CROSS EXAMINATION

BY MR. LAWLESS:

Q Dr. Wolfson, you have seen Dr. Sell when?

A I beg your pardon?

Q You said that you have seen him for under six hours, it wasn't clear how long you had seen him. When did you see him?

A The lengthy interviews that I can recall, were on the morning after his return to our facility. I do not have with me materials that would specify that date, although they'll be in the records there.

Q Okay, hold on. Is this what you are referring to?

[104] A Yes, the second time.

Q Great.

A And at some point, –

Q When you say "returned to this facility," which time?

A For his present hospitalization. He had been at the facility prior to that time also, and I probably encountered him, but I don't recall. It had been enough years ago, but upon his return back here, – there in Springfield, this would have been April 20th, and I saw him April 21st.

Q Is there a note there?

A Yes.

Q Your note?

A Yes.

Q What does it indicate?

A It states, "Patient wishes to resume customary dose of Paroxetine," –

Q Which is what?

A Paroxetine is an anti-depressant, P-A-R-O-X-E-T-I-N-E, – which he had been taking, prior to his incarceration". And as I recall, it had been interrupted in jail custody, or something like that, because that wasn't automatically renewed upon his return until I saw him and ordered it.

[105] Q Okay. Do you have your notes there?

A Well, they are within this, –

Q No, no, from that meeting on April 21st?

A No. I was not taking independent notes besides what's in the chart here.

Q What's in the chart?

A The chart is, –

Q The sentence you just, that's the, –

A Yes, that's correct, – there's an admit note, written by his attending. But in my role as consultant, that's what I wrote.

Q That sentence you just read?

A That's correct.

Q Nothing else?

A Nothing else.

Q How long did you see him for?

A I was present for the duration of the intake interview, which was typically forty-five minutes to an hour.

Q Do you know how long it was this time?

A No.

Q And the next time you would have seen him?

A If my memory on this is reliable, it was long enough ago that I may not have these in correct order, the next lengthy meeting within, – for which there is [106] career documentation, so that I can specify the date, would have been his due process hearing. However, –

Q You are counting, sitting on the opposite side of the table from him in room as being an interview with him?

A Contact with him, he did speak. He was in front of me for a long time, I was able to observe him. I spoke, I was able to watch his reactions to what I was saying. I would count that as, – as, meaningful time with somebody. Granted there were the distorting nature of the rest of the

circumstances, but I was in his presence. Anyway, what I was getting ready to say was that sometime in between those two documented points that I can read in a short time with him, I had at least one fairly lengthy meeting with him. He had questions about medications, going into psychotic medications, he had questions to ask me about Paroxetine, and other related questions to that.

Q When was that?

A I don't recall exactly, my best memory is that it was within two weeks or so after his arrival.

Q Are there any notes that you took as a doctor, that are in his chart?

A I don't believe that there are, I don't recall making them, and I don't see one, so, –

[107] Q Is this your habit, not to make notes about conversations with your patients?

A Well, let me remind you that I'm a consultant, basically, other than assessments, approaching Dr. Sell about his possible voluntary use of medication. I don't have what I need to be able to work until we have either a form of consent or some substitute thereof.

Q Let me get this, – you were the person that is suggesting the administration of drugs, either voluntarily or involuntarily?

A Yes.

Q Okay. And you are telling us that, – that your practice is to administer the drugs first, and then get to know the person, second?

A No. What I told you, perhaps not as articulately as I might if I had thought about it through further, is that I was not in the role of the individual responsible for generating the majority of the documentation relating to Dr. Sell. I was well familiar with Dr. Sell, and previous documentation had already been developed about Dr. Sell. Had I been his attending, I would have a hand written note from his first arrival there, and the copious other documentation, as I do with the patients whom I attend upon their arrival, to prepare a forensic evaluations. In this role of [108] consultant, when things are happening with Mr. Sell, – Dr. Sell, it would be more reasons to document, frequently, when he is essentially on hold as he has been. For legal reasons, whatever I document is likely to be duplicative to what Dr. DeMier's already writing in the chart, and that's not being consistent with what consultants do in other scenarios.

Q Well, forgive me but my experience says to the contrary, with regard to the documentation, that consulting physicians provide back. Generally, they provide quite lengthy written reports back to the referring physician. But, you have one sentence in that file, that refers to your contact with Dr. Sell before you formed the opinion that he should be medicated?

A I have one sentence, relating to the immediate issue at the time, which was that he wished to continue anti-psychotic, – anti-depressant medication. I also conducted an informed consent discussion with him, which is memorialized on a form that doesn't say very much, and Dr. DeMier most likely took care of the other form that would have to be filled out at that time. I wouldn't equate that with the level of assessment that I carried out. Had I been the attending, there would have been no one else to

write detail notes in the chart, but me, and I would have done that as the consultant.

[109] Q You didn't write any, –

A But the duty falls to someone else.

Q Well, was there another physician present?

A No, I was the only physician present.

Q Now, you have stated here today that, I guess you are unwilling to give a diagnosis, with regard to Dr. Sell, is that right?

A No. I have reservations, and don't want to portray, the diagnosis of delusional disorder, the plausible one as necessarily the correct one. There are some feature of his early course to the extent that we know about it, that would appear inconsistent with that.

Q Such as?

A Well, there a remark in the records from Barnes in 1982, in which it is recorded that he appeared to have had hallucinations, I don't recall the precise phraseology, I can find it.

Q That would be good.

A He had delusions on probably auditory hallucinations.

Q Probably, auditory hallucinations?

A Yes.

Q Of what duration?

A That's not specified, but it was related to his initial presentation, which appears to have been fairly [110] dramatic. My understanding is that he felt that there was a leopard getting onto a bus outside of his office.

Q That would not be an auditory hallucination, would it?

A No, but that indicates a fairly severe dysfunction, a problem with psychotic symptoms. And although, many patients know not to report hallucinations as one clear tangible, sign of dysfunction –

Q What, what –

A – a clue the doctor suspected it. He was correct.

Q What was the source for the claim that he said he saw a leopard getting on the bus? Was that something that he reported himself, or did a third party report it?

A I believe he mentioned something about that, and it's mentioned somewhere else on the copious source investment counselor had, but I did not recall where. There were other aspects of the episode that were reported here.

Q Can I look at that?

A Sure.

MR. LAWLESS: Could I have a moment, Judge?

THE COURT: Sure.

(Pause)

BY MR. LAWLESS:

[111] Q This was in 1982?

A Correct.

Q Okay. Are you aware of any other documentation, regarding hallucinations, from 1982 up to the present time?

A As I recall, this was the only instance where that issue was raised.

Q And that says probably?

A That's correct,

Q All right. Now, for a diagnosis of schizophrenia, don't there have to be prominent hallucinations, – recurrent and prominent hallucinations, isn't that part of the diagnostic criteria?

A That's part of the illness, that's not always part of what the patients will report. And, in particular, Dr. Sell appears to have been able to remain away from psychiatric detention for fairly lengthy periods of time. And certainly, remain away from the kinds of crisis style interventions, such as his 1982 admission Barnes. So, that's a potential distorted feature, related to the second concern that I have, which is that this is a fellow that has displayed very high functioning, at times, and yet is now responding to a serious mental illness. One would have to cause it that he had maintained a delusional picture bearing a [112] delusional concept, where a delusional picture more or less continuously since the onset of his illness until the presentation to us.

Q Delusional.

A Yes.

Q Yes.

A And if that were the case, one has to wonder, how he was able to continue functioning that well. An alternative hypothesis, is that he may have had the illness that was relapsing and remitting, and in episodes where it got worse and then episodes where it got better again. And, that would also fit the notion of the person who presents with serious symptoms and then doesn't have to keep going to the doctor repeatedly, or getting or having the circumstances compel them to have more or less continual contact. If that is what indeed happened to him, back then – I was not there to witness it, then, that would also be discord with the notion of delusional disorder that would suggest a more favorable prognosis, schizophrenia, –

Q Excuse me, pardon me, pardon me. Isn't one of the earmarks, of the difference between a diagnosis of schizophrenia, and delusional disorder, the ability of someone to be able to function, in the rest of their [113] life?

A That is not completely adequate to delineate the two disorders, there needs to be, –

Q You are familiar with the *Diagnosis of the Statistical Manual 4*, of the American Psychiatric Association?

A Yes. Yes, I am.

Q Okay. And it's what your institution uses in making diagnoses?

A I, –

Q Well, do you, – do you rely on the criteria set forth, therefore making diagnosis?

A We make use of the criteria, there. I'm a little uncomfortable with the notion of characterizing is what our institution uses, is some type of a regulatory dictum.

This is a book that is extremely useful in standardizing diagnostic terminology, and our field has certainly profited by it's development.

Q Okay. And with regard to the diagnostic criteria, for Delusional Disorder, doesn't it say, as one of the diagnostic criteria particularly ('C):

> "Apart from the impacted of the delusions, or it's ramifications, functioning is not markedly impaired, and behavior is not [114] obviously odd or bazaar".

A That is one of the expected features of Delusional Disorder.

Q Okay. And with regard to Schizophrenia the diagnostic criteria for that, specifically, Diagnostic Criteria B,

> "Social/Occupational disfunction for significant portion of the time, since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self care are markedly below the level achieved prior to the onset"?

A That is a feature seen commonly, –

Q Yes or No, is that what it says with regard to the diagnostic criteria?

MR. MARCUS: Judge, I'm going to object to him asking, – let him show him the book.

MR. LAWLESS: All right.

THE COURT: Okay. Just, please, Dr. Wolfson, try to answer the questions the best you can, if it's based on, – Mr. Marcus can give you the, –

BY MR LAWLESS:

Q Is that your understanding, what the diagnostic [115] criteria is, –

A Yes.

Q – for Schizophrenia, –

A Yes.

Q – and then I have marked with, I think, my pen, –

A Okay. Okay, yeah, that's what we have here, and to the extent that the book is usable, –

Q All right.

A – and that's what we rely on.

Q Thank you. And, from the history that you have observed and Dr. Sell's file he was employed, up until the time of his arrest as a dentist, is that correct?

A That is correct.

Q And at the time he was arrested he maintained a medical practice, I believe it's at 777 New Ballas Road?

A I don't recall the address, but it's my understanding that he had been functioning well.

Q All right. That's Highway 40/64 and New Ballas, Fairly Tome Medical office building.

A I'm not sure what the name of it was.

Q Yeah, all right, okay. All right, so he was able to maintain himself there, you don't have any mention of hallucinations after the '82 incident that you've talked about. Now, what text do you consider authorative in the area of psychiatry, Doctor?

[116] A There are a variety of textbooks, just about all textbooks have a certain level of flaws. Which text you use depends on what particular question was examining their, –

Q How about for Delusional Disorder?

A I'm not sure I consider any text definitive on Delusional Disorder, they are useful, but it's, –

Q What text would you consider useful?

A There are two books that Dr. Retterstol has published.

Q Retterstol, how do you spell that?

A R-E-T-T-E-R-,

Q I'm a real slow writer, I'm sorry, –

A R-E-T-T-E-R-S-T-O-L.

Q -S-T-O-L. Okay.

A And then just about every text book involving descriptions of psychotic disorder will include some information about Delusional Disorder.

Q Okay. Are there some texts that you rely on in your practice?

A I don't have any single text that I rely on in any standing fashion. I use books, *Comprehensive Textbook of*

Psychiatry, there's an UPI textbook of *Psycho-Pharmacology*, a book by Lashman, L-A-S-H-M-A-N, *Organic Psychology*, another text by Whitaker and Clayton. I [117] don't think of any of them as the one thing that stands out as the source of all the answers, with an entity like Delusional Disorder.

Q All right. With regard to the patients that you've testified to having benefited clinically, I think you talked about three, that would have been what, outside the legal settir g?

A Correct.

Q And, four, one, twice, a total of five admissions, if you were, – now you say they've benefitted clinically. What, does that mean?

A Well, there's an interesting feature here, is this I believe, which gives rise to notion of diminished response to anti-psychotic medications in Delusional Disorder. I have not typically been able to root a patient with Delusional Disorder, – preexisting delusional ideas, the way is often feasible, to do with a patient of Schizophrenia.

Q As far at their hallucinations?

A No, we are talking about delusions.

Q Okay.

A Sorry. Hallucinations either occur not at all or rarely in delusional disorder, depending on, –

Q Right.

A – hallucinations, by whose definition you accept. [118] Regarding, delusions not all patients with paranoid

schizophrenia or other psychotic disorders will have complete remission of delusional material, but many will and that's always the goal. My experience with patients with delusional disorders has been different, and in some ways it was strikingly how similar it was to those reported inside these case reports. The first flaw is to reduce the extent to which delusions inform and determine behavior. Second agenda also needs to be to try to not have a patient's delusional system continue to expand, as some tend to. If that continues without interruption, eventually it will be had to think of them in that box as someone preserved functioning, and although there's fears, that's in the DMS and that's typically happened. What one seeks to do is to support the patient, treat the patient to the point where, –

Q What do you mean by "support the patient"?

A Well, typically all of the patients with delusional disorder, all of them were basically reduced to treatment by some problematic occurrence. None of them came in saying, "I'm ill, I'm in distress, please help me". All were forced, often through interaction with legal system, to be put into a situation, –

Q Okay.

A – voluntary or not, –

[119] Q Okay. I understand, I thought Springfield was probably there because, –

A That's of all of them. That was also of patients at Barnes and the Washington University Clinic.

Q What do you mean by support the patients?

A So, what own wishes to do is to minimize the extent to which the delusions that interfere with their functions.

Q When you say support the patient, that was something as I understood it exclusive of medication, what did you mean by, –

A I did not intend it to be exclusive of medication, it doesn't work without medication.

Q What do you mean by support the patient?

A Once medication is employed, then psychotherapy of a level of sophistication and diplomacy, not ordinarily required of patients with schizophrenia, is of value.

Q Okay. Any treatment prior to the application of medication?

A Well, you do that anyway, with someone in the hospital, it's never really done any lasting good, anything more than momentary comfort, if that, until the medications are used. I mean one doesn't simply put pills in people and ignore them while they are in the hospital. But, I don't want my statement that the [120] psychotherapy is useful afterwards, to be confused with the notion that the psychotherapy is independently helpful. Does that answer your question, sir?

Q No, but that's all right. Dr. Sell is currently in unit 10E?

A That's correct.

Q Okay. And, what is your understanding of why he was placed there?

A He was placed there initially on an administrative separation order, I'm sorry, administrative detention order, by Lieutenant, and he is here now on a clinical observation order, authored by Dr. DeMier.

Q How often is that renewed?

A Weekly.

Q And, I believe your testimony on direct examination, was that it would be absurd for someone in his position to say he was in love with his nurse?

A To not desist in, –

Q What gives you the impression that he didn't desist?

A He kept approaching her, and his remarks, –

Q What was the initial approach, – what, he called her by her first name?

A My understanding that this is probably something that began long before I ever heard about it. So, by [121] the time this information found it's way to me, it had already been an existing problem as it were with him being a, –

Q Okay, well, you're insisting that he persisted in this, and that this is a basis for claiming that he's really just off the deep end. And, I'd like to know exactly what it is you claim he persisted in, because the notes that I've reviewed indicate that he addressed her by her first name, – she said it was inappropriate, – he then said, "you don't seem to like me as much you used to," which may or may not have been a reference to the fact that he had asked her to serve as his staff consultant at the hearing. And it was

only afterwards when he was locked up that he made any statement about loving her, to supposedly some guard in 10E. I don't see anything in her complaint that talks about that?

A My understanding, from what I can recall having heard at the time; was that there was an escalating pattern of over familiarity, merely obnoxious looking at first. What I find striking, about it is that, –

Q What, I would like you to look at the documentation for your conclusion, that, I'd like you to review that record, there, right now, and point me to the documents that support what you're drawing your conclusion from?

A Some of what I recall is not in the documents here.

[122] Q Where is it?

A Information is shared with us verbally, in morning meeting, every work day, we have informal interactions with nursing and correctional staff, –

Q There are nursing notes in there?

A There are nursing notes in there. Not everything that they tell us, –

Q There are correctional officer notes in there?

A At variables.

Q There are doctor's notes?

A There are doctor's notes.

MR. LAWLESS: Can I look at that for a moment?

(Pause)

BY MR. LAWLESS:

Q This is an incident report, dated July 24th of this year, is that right?

A That's correct.

Q It says,

> "Inmate came to nurses station for aspirin, he wanted to continue talking with this writer, and I told him I didn't have time. He stated, "You never have time for me anymore, I'm not special anymore". [123] He proceed to tell this writer, "You just don't realize what you mean to me". Inmate was given a direct order to leave, that his behavior was out of line. He then stated, "I can't help myself". He has approached this writer in the past and stated, "Hello, Michelle". He has been reprimanded before for his inappropriate behavior towards this writer."

So apparently, you can't call nurses by their first names, is that right?

A That's a breach of the carum, at least on occasional circumstances, it has implications beyond that.

Q As I understand, in the institutional rules, developing any kind of relationship with a nurse, viewing them as someone who is helping you or assisting you, that's wrong too?

A There's nothing wrong with helping or assisting, but a nurse in any setting, not merely a correctional setting, is a treater not a friend, and it's like I said it probably maybe innocuous, fairly innocuous, mildly undesirable in some circumstances, with potentially part [124] of a greater concern, as it was here.

Q Perhaps he confused being a doctor with being a nurse, but I don't think there is nothing wrong nurses being friendly with their patients.

A I'm sorry was that a question, sir?

Q No. The incident report prior to that is that Dr. Sell was in the pill line without water. Is that right?

A Yes.

Q Okay. And then he was directed to get water and return, he did not but remained in the line making a personal comment to the nurse about the appearance of her teeth. Okay. He told her, "she had nice looking teeth". "I shut the door," – he is a dentist, right?

A Dr. Sell?

Q Yes.

A Yes.

Q When he returned, he said that, "I was a result of poor breeding". And that's referring to a male, is that correct?

A That's correct.

Q I assume from the incident report, that the person wrote it understood what he meant?

A No, the person that wrote it is a psychologist. So, if the doctor read it, I would hope that he would have understood.

[125] Q Okay. And that's Richard Fredrick?

A That's correct.

Q Okay. And then there's Dr. Sell's version of the event?

A Actually, there are two versions. One version would be here (indicating), – and on that occasion he denied ever speaking to Dr. Fredrick, at all, ever in his entire life.

Q Okay. That was not written by him?

A No, this is, – each incident report is investigated by on of the correctional supervisors, a Lieutenant, and they take a statement, and memorialize the statement here along with what they call relative facts. And then in addition, if the incident report is sustained and forwarded on the unit disciplinary committee, then there is an opportunity for the prisoner's statement to be memorialized again. And if it goes from there to the disciplinary hearing officer, then there would be yet another occasion on which his statements are taken down.

Q Is this statement that's attributed to Dr. Sell endorsed by him in here or not, by him in any way?

A I beg your pardon?

Q Did he sign it?

A No.

[126] Q He wrote a statement, saying, in fact, that Dr. Fredrick slammed a door in his face, is that right?

A I haven't read the statements, so I guess I shall. (Witness reviewing document.) I'm sorry, your question again?

Q In his version that he wrote out there in his own hand, he stated that Dr. Fredrick's had slammed the door and it came to Dr. Sell's face, is that right?

A Yes, with such violent force that he felt the glass window door would shatter in his face.

Q Those are the instances of his escalating familiarity with the nurse, telling her she had nice looking teeth and then saying she didn't have time for him anymore?

A I would not characterize those as being the totality of the information. That's the totality of the documentation accessible to us here. At the time he was receiving the incident report, I then heard retrospectively that there had been a pattern of increasing familiarity, something which in his case would lead to substantially greater concerns, than it might just in a vacuum.

Q Concerns of what?

A Well, the investigative materials that we got, prior documentation, showed a tinnitus pattern of [127] pursuing a problem or concern, repeated letters to the Dental Board, letters complaining to public officials, just not letting go of a problem. I remember it much more, more in this way, but they believe in the materials are in the statements from some of the witnesses, –

Q Witnesses to what, I'm sorry?

A To his initial Federal case I believe, I don't recall which particular investigative material I saw this in, but there was a concern about familiarity, a sort of warm inclusion his office staff, beyond what you may see in some offices, and then bill verification of one staff member. Problems with boundaries and that can be a concern in

somebody who is paranoid, someone that has already been accused of attempting to arrange for the murder of one federal officer, now has another federal officer he's idealizing apparently, with whom he is seeking to smear out, make more a morphosis boundaries in role. Talking about wanting to use her as a model for her teeth, which it mentions, –

Q After, his release it says.

A – after his release, which is also against regulations, but more importantly, is, –

Q But what, what's against regulations?

A – Him having social or occupational contacts with [128] staff members after his release. I believe the recommendation is two years, but, –

Q But he hasn't been convicted of anything, you mean to tell me if he was found not guilty or released, that he can't talk to whomever he wants?

A It's an issue of the people who he would be talking to, should be maintaining contact with him. I don't know of any sanction that would be imposed upon him, –

Q All right.

A – or calling or writing, but it's inappropriate for, more or less to nurture that type of thing.

Q Okay. But he's the one that's in 10E?

A That's correct.

Q Okay. Has there been any discussion with him, regarding progressive plans for him to get back into general population?

A I'd have to defer to Dr. DeMier on that question.

Q Okay. That hasn't been part of these informal discussions, that don't appear in his record?

A I'm sure it has been, my perspective on it that his best chances for going back out to population and succeeding, without further problems, will be at such a time that he is treated and this whole subject will get much easier to cope with. While we have an untreated illness, which appears to be in more problematic [129] condition, than it was when we met for his due process hearing. I don't anticipate things getting better, until a meaningful intervention is made, which is what we would like to do.

Q So, essentially what you are saying is, that from your view is that unless he is medicated, he is going to stay in 10E?

A I don't know that I have to hold that position programmatically, but I would like to see him medicated and not on that unit, our best way to help him and to alleviate the situation without having to deal with escalating risk.

Q And he had been there twice before, and not having to be put into 10E then, right?

A He'd been here twice before, and he's been through locked units, because everyone we admit arrives in them, and I do not recall him ever being moved back, to a locked unit before.

Q Okay. In fact, that was only after a determination was made on your part, that he should be medicated, that his condition was viewed as escalating and he was placed in to 10E, isn't that right?

A It's no surprise for his condition to escalate if it's not treated, but yes, the order in which that happened, if you wish to conceptualize it that way, this [130] problem developed well after the issue of medication was raised, several weeks.

Q Right. Now, I had a, – I don't know that I have another copy of that, –

THE COURT: This, Exhibit #1?

MR. LAWLESS: No, sir. I'm sorry, I have this marked as Defendant's Exhibit A.

THE COURT: This.

MR. LAWLESS: Yes. I was just thinking about this.

THE COURT: Thank you.

BY MR. LAWLESS:

Q And that is a report from the, – another Federal medical center, is that right?

A No. It's from the Metropolitan Correctional Center, basically, a Federal jail, in Chicago, it's not a medical center.

Q Okay, all right. Are females treated there for medical problems?

A Well, females are confined there, and if they have medical problems that aren't too serious to be held, they are transferred to local hospital, then they would be kept within in side the parameter. What I recall is that, Chicago has a small infirmary and a couple of cells with

monitor, – with the capacity for monitoring [131] people, –

Q Okay, just looking at the first paragraph of the report, doesn't it indicate that a Magistrate Judge here in the Eastern District for Missouri referred this person to the Bureau of Prison for forensic alveolation and it was the Bureau of Prisons that designated her?

A That's correct. That they do have a forensic psychologist there and they do forensic studies. But, it is not a medical center.

Q Okay. So, they did a forensic study there, and in the body of this report, turning your attention, –

> "This person is diagnosed with, – is suffering from delusional disorder, and at page seven under prognosis, the third sentence it indicates, – "Individuals who suffer from a delusional disorder often do not respond to mental health intervention,"

is that what it says?

A That's what it says.

Q All right. And then on page eight, the paragraph that starts at the bottom of the page,

> "As noted in the prognosis section, delusional disorder does not [132] typically respond to pharmacological intervention or psychotherapy".

And, you disagree with that, I take it?

A Well certainly, I have a basis for disagreement with it.

Q And you disagree with Dr. Cloninger, on the basis that he has for saying that?

A I disagree with the legal reasoning, that Dr. Cloninger makes in his Affidavit to go from abstinence to the kind of systematic double blind, placebo trial studies that we like to have, and which we have are more disorders, and after schizophrenia to go from there, to the notion of withholding treatment, for a condition that's been demonstrated in our experience and in the literature to respond to treatment.

Q Do you know Dr. Cloninger?

A I trained at the University where he was a member of the facility, not personal friends, or anything like that.

Q I would assume you wouldn't call a personal friend irresponsible?

A Well, at least not in court. The statement is what's irresponsible.

Q And, the portion of Dr. Cloninger's Affidavit that you found problems with again, if you could go over that [133] with me?

A Yes, I have it.

Q Good, so do I. Can you tell me what, –

A Oh, what the problems are, right, sure. I thought you were going to ask the questions.

Q No. I want to try to understand your statement.

A Okay. Well, I mean there are several problems, but I would present the key one as follows: There is as I said, a

leap for reason is the most appropriate way to put it, from the Opjordsmoen and Retterstol study, showing that a cohort of patients followed currently in the direction of neuroleptic medication,

Q Your are citing this part of the Affidavit here?

A Item seven.

Q Okay.

"Yet there appear the effected the neuroleptics in the treatment of schizophrenia as well as established some reports indicate that at least Pimozide may be effective in delusional disorder as well. In this article, a long term follow up of seventy-two first admitted patients with delusional disorder is described. Outcome in the group [134] admitted during 1946 to '48 was compared with that of patients admitted during '58 to '61. We did not find a more favorable outcome in the group admitted after the introduction of neuroleptics."

A Yes.

Q Okay.

A And Dr. Cloninger believes from that research finding to a statement in the next item,

"There is no evidence that neuroleptics are beneficial for patients with delusional disorder."

That can't be justified and, in fact, that you can see easily yourself, that at the beginning of paragraph seven, he mentions,

"Some reports that at least Pimozide may be affective in delusional disorder."

Pimozide, is a neuroleptic medication, so there is a contradiction right there, within that seven lines.

Q It says some reports indicate that, however this study, of seventy-two patients indicated that there was nothing more favorable after the introduction of neuroleptics?

[135] A Yes. And from there it goes to, there is no evidence. There is much more evidence out there than he cited. But he already cited evidence.

Q All right. Now, you are familiar with the appeal that Dr. Sell filed from the hearing?

A I was actually not the person to consider it, so I know that he filed an appeal and I glanced at it. I've not painstaking read through the entire, composition, –

Q You, he discussed that with you and the, –

A Well, he told me that he'd written it intending for me to read it rather than the person judging the appeal, which is another concern, about unrealistic understanding of a situation. And if he wishes, I hope to read the whole thing at some point, but there is a, if not painstakingly gone through the entire exposition it's a document that was intended, or should have been intended, for the administrator hearing the appeal.

Q Well, it certainly was written to them also. But, in there he cites the sixteenth edition of the *Merc Manual*, of diagnosis and therapy. Okay. Are you familiar with the *Merc Manual* on diagnosis and therapy?

A Yes.

Q Okay. And it's just a general, – it would be like a medical dictionary?

A It's a little more fancy than that. But, it's not [136] a definitive text for any of the specialties that are encompanied, – that are encompassed, within general practice.

Q Okay. However, it does state that as a general rule, treatment of delusional disorder with drugs is not the treatment of choice?

A I don't recall if it says that particular thing or not, I imagine it probably has, – includes the same misconception or extension of the differential manor in which psychotics tend to respond to delusional disorder, as did Dr. Greenstein, as does Dr. Cloninger here. Those of us who treat these patients, of course, see that they do respond. They respond differently, and it's more a complex and more difficult undertaking.

Q Okay. Your testimony, is that the delusions themselves, respond to medication?

A No. My testimony is that, the, – first the delusions stop expanding, when treatment works. It's even conceivable that some delusional material may regress. For example, one of the patients had been convinced that there were people coming into her attic, and then some months after treatment started she conceded that, – well, maybe there might have been squirrels in the attic. But, to continue with this illustration, the notion that her neighbors had been [137] harassing her and looking through her mail slot, wanting to steal the mantel piece clock, that never went away. However, she stopped believing that they were still trying to do it, she stopped having

her behavior become influenced by these beliefs. She did not engage in a further wrestling match with the sheriff over the shotgun that she had, which is what had brought her to medical attention. So, then, woman in their fifties don't usually engage in such behavior, so our first goal was to diminish the impact on her actions and her judgement of the illness. Second, was to minimize the expansion of the delusional system. That's was accomplished, and it's typically been my experience to be accomplished with other patients. It would be nice if, as one often does with schizophrenia if the person would say, "You know, I've realized that my thoughts were distorted and that must not have happened that way". And, it's not realistic to be able to accomplish that with patients with delusional disorder. Now, that truth, which turns out once I've searched the literature to be more widely understood than I'd realized, has gotten mangled into the notion that, patients don't respond. They respond differently. And in terms of the specific likelihood of abolishing a particularly delusional belief, rather than lessening it's impact, [138] than in that manner, anti-psychotic medications have a lower rate of effectiveness.

Q Okay. The documents that you've identified, – endorsed here in Government's Exhibit #1.

THE COURT: One. Do you need to get it?

MR. LAWLESS: No sir.

THE COURT: You've got it?

MR. LAWLESS: I think so.

BY MR. LAWLESS:

Q Okay. Do you have those in front of you, sir?

A They are in this stack here I can find it.

THE COURT: Here you go.

THE WITNESS: Actually, Your Honor, I'd prefer to use mine.

THE COURT: Okay.

THE WITNESS: Since mine are a little more, – here they are.

BY MR. LAWLESS:

Q Okay. I don't know if ours are in the same order, but, the first one I have here says, monosymptomatic hypochondriacal psychosis manifesting as delusions of parasitosis, is that, –

A Yes.

Q Okay. Now in the DMS-IV, it makes note that hypochondriasis is to be differentiated from delusional [139] disorder, does it not?

A Yes. As we used those terms in 1995 or 1997, yes.

Q They are different?

A They are representations of different concepts.

Q All right. And, what is monosymptomatic hydraclorineal, – (blah, blah) (laughter)

A Hypochondriacal, –

Q Great.

A Well, this paper was published in, –

Q What is that condition?

MR. MARCUS: I'm going to object. He's trying to answer the question the best he can, your Honor.

THE COURT: Okay, all right. Go ahead.

THE WITNESS: Okay. Seeing as this paper was printed in 1978, and the modern form of the DSM, which began with DSM-III – the third edition, DSM-III, in 1980, hadn't even come out yet, this is terminology for what today would be classified as variative delusional disorder. So long as one were cautious enough to make certain that it simply wasn't someone with hypochondriasis.

Q Hypochondriasis is what?

A Hypochondriasis is a persistent non-delusional, non-psychotic, but perhaps obsessional preoccupation [140] with one's state of health, physical health typically.

Q Fearing that one has a serious illness, that one, in fact, doesn't have?

A Usually several serious illnesses.

Q Well, okay, when it says monosymptomatic, I think that means one symptom, is that right?

A Well, I think that what the real meaning of this was that, this was somebody with delusions confined to one realm, just as you described when you are, –

Q Okay. And hypochondria, as we understand it is someone who always thinks they're sick?

A Yes.

Q Okay. Dr. Sell doesn't think he's sick, does he?

A No.

Q Okay. And, I haven't had an opportunity to review these since we were just given them in the court today, but when you look at this, it says, "Report of cases, one is of a woman who thinks she has insects crawling all over her body, and she thinks she has a parasitic infestation," is that fair?

A Yes.

Q Okay, that's case one. In fact, she didn't have a parasitic infestation, right?

A Well, more than that, she had a delusional conviction that she had a parasitic, – not alleviated [141] by comfort or reassurance, that's without the transiently working out, with real hypochondriacs.

Q Okay. And then case two, is a seventy year old person, who thinks they've got fleas?

A Yes.

Q Okay. And case three is a fifty-six year old woman who complains of an insect infestation in her house?

A Yes.

Q And case number four is a twenty-nine year old man, who probably had a genuine attack of pubic lice, which was treated successfully, however he then developed itching all over his body, –

A Well, –

Q – shaved off his hair?

A – he bought a microscope, –

Q To look for insects, okay. Thought he was sick. But those are all different, in kind, from the delusion that you are talking about with Dr. Sell here. These are all people having delusions with regard to themselves, and things happening to them in their own little body, are they not?

A No. I wouldn't say that they are different in kind, they are different in content.

Q You don't differentiate hypochondria from delusional?

[142] A For a psychics symptomatology in general, typically in the form of the symptoms are more important than the content. Let's take hallucinations as an example, just because it's the most tangible one. If someone is hearing voices, it is less important whether the voices are your mother-in-law or some public figure, and more important that they are hearing voices. Sometimes the content then will direct itself to problematic things. The same thing is with delusions. If you have delusions it's a problem. It interferes with function, the particular interference may relate to the content of the delusions, but the key feature to catch on to it first, is that there are delusion present that shouldn't be.

Q Okay. So you didn't differentiate between God talking to Moses and someone claiming that the devil told him to kill somebody?

A That isn't really a fair correlation to what I said. That opens complex problems about differentiating peoples religious views from psychotic symptoms. We can address in depth if we had more hours, and its, –

THE COURT But, we don't.

(Laughter)

THE WITNESS: As it happens with something to deal with, with considerable level of sophistication sometimes. What I'm saying is that before someone gets [143] hung up on the specific delusional content, the first fact to recognize is that delusions are present, and that in itself is a clear signal of abnormality. Once one is satisfied that they are truly delusions. These particular conditions that relate to these case reports have been grouped together with delusional disorder of the persecutory type, as appearing to have important commonologies. To the point that they are presently thought of as being different subtypes of the same illness. Sure it's different to deal with someone who thinks the government wants to destroy him, than it is to deal with somebody who thinks they have fleas, and is harming themselves with shampoos or shaving off all their hair. Their practical management on a day-to-day basis is different, but the illnesses appear to be similar, possibly the same illness if this is a unitary entity.

Q So you would be looking at this comparing this with the semitic type of hallucinational disorder as opposed to the persecutory type?

A That's correct.

Q And when you have people that feel they are being persecuted, who are paranoid, okay, would placing them in isolation tend to exacerbate that condition?

A Might conceivably, transitionally improve it, to [144] the extent that they are away from others, they are away from activity. Dangerous things often tend to happen

when they are at liberty to get into situations where trouble follows.

Q And you don't think there's any danger in 10E?

A 10E doesn't completely eliminate the possibility of danger, –

Q Isn't it rife with danger from staff?

A Rife with danger from staff?

Q Right?

A I can't see where you are coming from, there, certainly not rife with danger from staff.

Q All right. Inmates there are not, brutalized in an effort to administer medication to them?

A No. And we don't brutalize inmates period. That's not a way for anyone to be able to finish their career, in corrections with their retirement. It may be a way for them to live in our facility instead of work there.

Q The second paper that you talk about here, this Pathological Jealousy, I guess you would say, that it's a jealous type of delusional disorder?

A Parallel concepts, different terminology, from different eras.

Q Okay. Under today's criteria, would that be what would be called the jealous type, that's a subtype of [145] the delusional disorder?

A Yes. And actually, just give me a minute to find that citation. Are, you talking about this one (indicating)?

Q I wasn't holding it up, but that is what I was looking at, yes.

A Yes.

Q Okay. And the next one I have, again talks about the treatment of monosymptomatic hypochondria, that's –

A Byron (phonetic) Monroe.

Q Right.

A Yes.

Q Okay. So again, that's about the semantics subtype of delusional disorder, is that right?

A Yes.

Q Okay. And then the next paper you have is by, again by Monroe, is that right?

A There were three by him. Which journal is it?

Q Well I just have one, that says delusional disorders, I can't tell what, –

A It would be down at the bottom of the page.

Q *Psychiatric Annuls* from May of '92, is that what you have?

A Yes, I believe so. Yes, and the *Psychiatric Annals* on this page.

[146] Q Okay. And then they talk about the misdiagnosis of delusional disorders, sometimes as being schizophrenia?

A Yes. That certainly is a potential problem and analogy, so is the reverse.

Q You have little idea of the frequency of the delusional disorders? And they talk in, – in here it talks about treatment with this Pimozide, for the somatic subtype, jealousy and then I think it's the erotomania subtype, is that right?.

A Yes.

Q Those are the subtypes he is discussing?

A I would imagine that those are probably the subtypes for which he has access to patients who will stay in treatment without being cohersed.

Q Okay. And then the next paper that I have is from *Comprehensive Psychiatry*, is that right? Is that the next one you have?

A Yes.

Q Okay. And that's Delusional Disorder Paranoia. And there in treatment, which appears on what, reprint of page 517, is that right?

A Yes. We are in treatment of contact of antipsychotic drugs, neuroleptic drugs.

Q Well, they say,

> "Most patients in the study had no [147] treatment, but seven had psychotherapy and five were given neuroleptic drugs, right"?

A Correct.

Q "Of the seven who were given some kind of psychotherapy, three were considered improved at the time of discharge," is that right?

A That's what it says.

Q Okay.

"And follow up however, one of these was clearly chronically ill. Thus two out of the seven were considered improved at discharge, and at least socially recovered at follow up. Of the five patients who were given neuroleptic drugs, three were considered improved at discharge. Of these three, there was no follow up in one, and another the patient was clearly chronically ill after a follow up at six months, and the third, after a follow up of two to three years, the patient was at [148] least socially recovered."

A Correct, it says that.

Q Okay. And then the last one we have here is the Nostalgic Validity of Paranoia is that right?

A I think we skipped another one, but that's correct.

Q Well, it could happen, I'm not, maybe I don't have it.

A I hope you have it, I brought you a copy.

Q Well, these are all of them that I have.

(Pause)

MR. LAWLESS: Ah, there it is. Successful. Treatment of Litigious Paranoia.

THE WITNESS: Yes.

BY MR. LAWLESS:

Q Okay. Here we have an eighty-five year old man brought into the hospital for psychiatric treatment, is that it?

A Yes, in handcuffs.

Q In handcuffs. Tried to demolish his sons house with an ax, claiming it was his property, and was charged with trespassing, intentional damage and disorderly behavior, had no medical, psychiatric or forensic history, is that right?

A (No verbal response.)

Q At age eighty five?

[149] A Yes.

Q Okay. That's an unusual age for the onset of delusional disorder?

A The problem with delusional disorder is that it is difficult to be sure when the onset is. These patients both in a series, I frequently read about at the turn of the century, tend to stay away from doctors longer than just patients with any other disorder until some precipitating event, like demolishing a house, compels it. Conventional wisdom is that on average, the illness is present for five years before initial presentation, but there is a broad range. I think Kragle had some patients who had been retrospectively, he was determined they had been sick for a long as nine years. So, it's hard to be sure, but it's certainly an unusually old, elderly age, to be presenting.

Q Okay. And then they treated this, – was there a diagnosis with this person?

A I don't recall exactly where in here they discussed diagnosis in the clinical setting before they initiated treatment. Although, they did mention that the pattern of intense litigation and started forty years before, when he

was forty-five. I guess that might conceivably lead one to conclude that the onset of those troubles was sometime during that period.

[150] Q Okay. Litigious paranoia. Okay. And so, they treated this person with this anti-psychotic medicine, right?

A Yes, they did.

Q And then, in their treatment, – first paragraph, the last sentence they say,

> "Whether or not Pimozide has this specific therapeutical affect on delusional disorders, suggested by Monroe remains to be seen."

They talked about tension subsiding at first, and that tension, there are other drugs available that can reduce tension, are there not?

A I think that that's not the main point of their statement. The question here deals primarily with specificity, that Pimozide is opposed to other anti-psychotic medications.

Q Okay. And it says,

> "Little by little interpersonal relationships, social and occupational functioning improve, but full incite never develops and the original conviction never completely disappears, although it ceases to influence their actions."

[151] Is that what he is saying?

A That's what he says, and if one made that just a little less dogmatic, it would represent my own views pretty well.

Q Okay. So to the extent that Dr. Sell has what you would call fixed false ideas, those ideas are not going to go away?

A They probably will diminish but not resolve. I certainly would not offer him that expectation, as I would someone with schizophrenia, or with psychotic symptoms from some other cause, that one can expect complete remission. That's what you always try for.

Q And then, I'm sorry, I just want to make sure we're on the same page, what is the last article you have there?

A I don't know where I put it in here, – it's by Kenler, –

Q Yes. Kenneth S. Kenler. And they go on to say that any definitive conclusions from the studies is impossible?

A They relate that to the lack of physical control group, which is the same consideration that I referred to earlier.

Q Right. Anecdotal reports were located claiming that patients with SDD responded to a combination of [152] neuroleptics and was it Triclocide (phonetic) antidepressants and lithium?

A Yes.

Q Okay. But they were unable to make, – draw any conclusion that they were willing to sign their name to?

A No, they were unwilling to portray this as definitive proof of these medications, being proven to be superior to the placebos. That's how I interpret their statement. There's a reason, in general we are cautious

with anecdotal experience, because there could be a multiplicity of factors, –

Q Could be misdiagnosed?

A I have less of a concern of that for these series they've quoted, but that's a problem with this illness, both potential with under-diagnosis and certainly with over-diagnosis.

Q All right. And as I understand Dr. DeMier's testimony, there hasn't been any other treatment attempted with Dr. Sell, to this point?

A Incorrect. Dr. Sell remains on the anti-depressant that he was taking, –

Q He was taking that all the time?

A Yes. Which he considers to be of benefit, and potentially may be. It may be that he would have further deterioration or further impingement of mood [153] disturbance as well, if he were not. I'm certainly not going to stop it just to find out if he does or not. And to the extent that's it's feasible to have a supportive relationship with his attending, which is sometimes a difficult endeavor in our facility, given the lack of confidentiality, that's being provided to him also.

Q That's being provided to him by his attending, –

A Clinician.

Q – clinician. Putting him in segregation, where he's locked down twenty-three hours a day in isolation? That's your testimony? That's how they're building a bond between each other?

A Well, I think you are putting words in my mouth, sir.

Q No, I'm just looking behind your words, at the reality, so that we can get some of that out here.

A Well, I would not agree with that characterization.

Q Is that where he is, is he in 10E?

A That is where he is.

Q Is that where he is locked down twenty-three hours a day?

A That is where his circumstances compelled him to be placed until something is done, –

Q Is that where he's locked up?

[154] A That is where he is.

Q With no break, contact during the day with anyone else, he's in isolation?

A He is not in isolation. He is not in physical contact with other people; there is traffic past his door, although, –

Q What is his door? What's this door made of?

A The door is made out of steel, with a glass window peaker vent.

Q So, it's not bars, it's a speaker?

A Right. Grilled if I need to talk to him, it's perforated.

Q Okay. He eats his meals in his cell?

A Correct.

Q He's taken out of there to take a shower and for recreation?

A That, and interviews with staff.

Q Okay. And we'll just have to trust Dr. DeMier's testimony as far as the frequency of his meeting with Dr. Sell?

A I see no reason not to trust Dr. DeMier's testimony about the meeting, – frequency of the meetings with Dr. Sell. I trust him whatever it was.

MR. LAWLESS: Okay. I don't have anything else.

[155] THE COURT: Mr. Short.

MR. SHORT: I just got a few questions Judge.

THE COURT,: Okay.

MR. SHORT: Good afternoon.

THE WITNESS: Good afternoon.

CROSS EXAMINATION BY MR. SHORT:

BY MR. SHORT:

Q You do know Dr. Cloninger?

A I've spent some time in his presence in educational lectures, when I was in training. I don't know him personally, particularly well.

Q And you were at Washington University, when?

A I attended medical school there, for the second portion of medical school, after I got a Master's degree

from the University of Chicago. I transferred into the third year class there and that was in 1985, graduated in 1987, and I did my residency in psychiatry in Washington University at Barnes Hospital, from then until 1991.

Q All right. So Dr. Cloninger was a professor of psychiatry at Washington University when you first came there?

A He was a professor of psychiatry, and in particular, had some teaching duties relating to one of our formal rotations at Jewish Hospital, which I did my [156] second year and then he became chairman while I was at the university.

Q Yes. In fact, he was chairman of the Washington University Psychiatric Department?

A He was for a time.

Q Yes. That time was five years?

A I don't remember the exact time, but I know that he left prematurely, but I don't recall the exact duration.

Q And I gather by those two cute comments, you mean something other, than, you have some problem, –

MR. MARCUS: Judge, I object to, –

MR. SHORT: Let me finish the question, you got some problem with the reason he left?

MR. MARCUS: May I make an objection now? There has been a continuous comment, – there's a little bantering going on through this doctor's testimony, I think he's due the respect he has as a doctor, as any witness in this courtroom is due, and I haven't objected to this, – I

don't want to disrupt the flow of this proceeding, but it's getting to the point where I think it is disrupting the flow.

MR. SHORT: Well, one of the problems, Judge, is the witness can't answer the question.

THE COURT: Okay. Why don't we just proceed forward here. We probably just, – although he may be [157] having troubles, Mr. Short, Mr. Lawless did also. I think, you know, you are getting the answers, maybe not as quickly as you like, but you are getting them, so let's just proceed in as civil manner as we can, while making the points we need to make. So, you may proceed Mr. Short.

MR. SHORT: Thank You, Judge.

BY MR. SHORT:

Q Was he the head of the department of psychiatry while you were there?

A He was head of the department of psychiatry for the second half of my residency.

Q Okay. Are you Board Certified?

A Yes. In both general psychiatry and forensic psychiatry.

Q When did you receive your M.D.?

A 1987.

Q All right. You would have used a couple times of respect to Dr. Cloninger's Affidavit, the term "leap of logic," or "leap of reasoning," correct?

A Yes.

Q Would you agree with me that you would be guilty of a leap of logic or a leap of reasoning if you were to diagnosis Dr. Sell as having an erotomania subtype of delusion? Based on that nurse incident?

[158] A Well, I haven't diagnosed him as having an erotomania subtype. It's a developmental phenomenon that's potentially of great concern. But, I haven't rushed to diagnose him with that subtype. And regarding the Affidavit, I have no choice, it gives me no joy but they're conclusions that don't connect.

Q Okay. But you're not telling Judge Adelman that you think the Dr. Cloninger (sic) suffers from some kind of erotomania subtype of delusional disorder are you?

MR. MARCUS: Dr. Sell.

MR. SHORT: Dr. Sell.

THE WITNESS: I don't know that Dr. Cloninger suffers from any disorder at all.

BY MR. SHORT:

Q Dr. Sell, you know what I meant.

A No, what I had a concern, that you were seeing a phenomenon that could potentially go some place undesirable. I have not specified this as being an erotomania subtype. In one sense it may not be fitting cleanly into any subtype, which is an additional grounds to perhaps question the diagnosis all together.

Q In fact, if I understand, your testimony, when you answered the questions of Mr. Lawless, that you've told Judge Adelman, that you would prefer to defer a definitive diagnostic conclusion and you preferred not to [159] be

pinned down on the medication to administer to Dr. Sell. Correct?

A Yes. I said those things.

Q Now, you know we're here to have Judge Adelman eventually make a decision as to whether or not involuntary medication should be administered to Dr. Sell, correct?

A Correct.

Q And you told Dr. Adelman, you can't tell, – Judge Adelman, you can't tell him what you want administered at this time?

A I can tell him that the various choices are, depending on which potential properties of the medications involved are more or less appealing to Dr. Sell. I plan to give him some flexibility in what he receives. If he refuses to cooperate, – if I'm given an order to treat and he refuses to cooperate with treatment, that will tie my hands as to using the medications I would most prefer to prescribe. So, the actual drug that is prescribed will depend on, in part, the circumstances at the time. I can give you a good summary of what the potential possibilities are, as far as the choices of medication.

Q But as you stand here now, you are not going to tell the Judge Adelman what you intend to administer?

[160] A I see no benefit to saying, "I will pick this drug now," dogmatically, if it turns out that Dr. Sell prefers Quetiapine to Olanzapine, than there is no reason why he shouldn't have some input. I don't see a need to dictate that much to him without, enough is being dictated to him as it is.

Q You also told Judge Adelman that it's your opinion that you can restore Dr. Sell to competency, correct?

A Precedent, with similar cases, would suggest that, yes.

Q And that's regardless of what medication what medication you eventually choose?

A It's regardless what medication, it's regardless of the quotable diagnosis.

Q Okay. And how long is that going to take?

A That I can't predict, it's ranged from as long as, – as short a period of time as a few weeks, which I would certainly not expect in this case, up to months.

Q And you understand that you do not get months, and months, and months to deal with this question, do you understand that?

A In some cases we have been given months, and months, but we're given commitments in increments of four months at a time, and usually without particularly adversarial proceedings, second four month of expanded [161] extension so that the period of extends to eight months, it has been offered in our patients who needed it. In a few cases where, then after going back to court, the District Courts have ordered further treatment for additional commitments. It depends on the circumstances of the case, and how much optimism I can offer as to further treatment having benefit.

Q Could months extended to over a year?

A The longest that this has ever gone on with the defendant, was probably about two and a half years, but

that's highly unusual. The majority of the people who we restore, we do it either within the four month period or we do it within the four month period with the form of an extension.

Q You also said that you believe that whatever medication you eventually choose, it would make him less violent, correct?

A I think it would reduce the risk of violent could behavior, at least whatever risk of violent behavior might be related to manifestations of his illness.

Q Because he couldn't get any less violent, now could he?

A I beg your pardon?

Q He couldn't get any less violent could he, he hasn't been violent at all?

[162] A We are holding him in a place where it's hard not, if not actually impossible, but very difficult for him to do anything violent. But, there appear to be some things in the recent past that are of great concern, including to his charges.

Q Well there wasn't violent in the time he was in open population was it?

A No, he wasn't. That's why he remained there.

Q So he can't get any less violent than he's been in Springfield?

A What I think we would like to see, –

Q Can he? Answer my question. Can he?

A He has not been immediately violent in front of me, so no, in his current supervised surrounding he has not been violent.

Q He hasn't been violent immediately or otherwise, has he?

A No, as from reports his conduct in jail, elsewhere, –

Q I said at Springfield?

A Not at Springfield.

MR. SHORT: That's all I have.

MR. LAWLESS: I don't have any redirect.

THE COURT: Okay. You may be excused Dr. Wolfson, thank you.

[163] THE WITNESS: Thank you.

THE COURT: Mr. Marcus, do you have any further witnesses?

MR. MARCUS: I don't have any further witnesses. At this time I would re-offer Government's Exhibit 1 into evidence.

THE COURT: Any objections to Government's Exhibit 1.

MR. LAWLESS: It doesn't seem real relevant to me, but, just being in front of you, – well you can figure that out on your own.

THE COURT: Why, don't I just take it for what it is worth as far as value is concerned, so I will accept it into evidence for those purposes only. And that is the

extent of the testimony you want to present, Mr. Marcus, is that correct.

MR. MARCUS: That is correct, your Honor.

THE COURT: Okay. Mr. Lawless or Mr. Short, I have the Affidavit of Dr. Cloninger which I'm going to, accept as if it were presented in this Court on this proceeding. Is there anything else you'd would like me to take notice of, any other evidence you'd like to present?

MR. LAWLESS: I have what I have marked as Defendant's Exhibit A, I'd move for it's admission.

[164] THE COURT: Okay. And it will be so admitted. That's the report from the Chicago Medical Center by Dr. Greenstein, correct? Yes.

MR. LAWLESS: We need some time to confer with our client, Judge, he was not available to us until this morning.

THE COURT: You may do that.

MR. LAWLESS: Yeah. We do need to do that, and I apologize to the Court.

THE COURT: Okay. How much time do you think you need, half hour?

MR. LAWLESS: How much can I get?

(Laughter)

THE COURT: You know, –

MR. LAWLESS: Half an hour would be fine.

THE COURT: Okay. Fine.

MR. LAWLESS: Thank you.

THE COURT: We will be in recess for half an hour.

MR. LAWLESS: Thank you.

(Temporary Recess from 1:00 p.m. Until 1:40 p.m.)

THE COURT: Mr. Lawless, or Mr. Short, are you prepared?

MR. LAWLESS: I'd like to call Dr. Sell.

MR. LAWLESS: Good afternoon, Dr. Sell.

[165] THE WITNESS: Good afternoon.

DR. CHARLES THOMAS SELL, DEFENDANT, SWORN
DIRECT EXAMINATION

BY MR. LAWLESS:

Q I'd like to ask you some questions concerning Michele Goldberg?

A Yes sir.

Q Okay. She is a nurse at the Federal Medical in Springfield?

A Yes, sir.

Q Do you know her?

A Yes.

Q There's been testimony here today about you making statements to a correctional officer that you "loved her," did you ever make those statements?

A No. I did not say that I loved her, I said I liked her.

Q All right. And that conversation concerning Ms. Goldberg, that took place in the 10E unit?

A Actually, it was 10A, unit but it was still a lock down unit before they moved me to 10E.

Q Okay, did, –

A They are very similar.

Q – you initiate that conversation or did the correctional officer initiate that conversation?

[166] A I did not initiate the conversation, the correctional officer came to my cell door, and initiated the conversation. Asking me why I was being locked down.

Q And, –

A Then I said I guess it was because of Nurse, Goldberg, –

Q Okay.

A – to the best I know, although I didn't know for sure.

Q All right. Did anyone speak to you prior to your being locked down, about your conduct towards her being possibly inappropriate?

A No. Never.

Q Okay. If they had brought that to your attention what would your response have been?

A I would have completely avoided Nurse Goldberg.

Q Did you mean to harass her?

A No, sir.

Q Okay. Do you love her?

A No, I don't love her.

Q Do you fanaticize, – pardon me go ahead?

A (No verbal response.)

Q Do you fanaticize about her in anyway at all?

A No.

[167] Q Okay. There was testimony that you referred to her by her first name?

A Yes.

Q Had you heard others do that?

A No.

Q Okay. Have you observed her on occasion to be flirtatious with others?

A Yes.

Q Okay. Have you observed others to be flirtatious towards her?

A Yes.

Q Okay. Was that prior to any contact you may have had with her?

A Yes.

Q Okay. Did you, – compared to that other behavior, did you feel that there was anything about yours that was out of the ordinary?

A No.

Q Okay. And, the incident that you were cited for, that eventually lead to your being placed in lock down, that took place approximately a day after notice was filed here regarding, – seeking judicial review on the issue of involuntary medication?

A Precisely. I was locked down on the Saturday, July 24th, and the appeal here to this Court was filed on [168] July 23rd.

Q Okay. You are, – before you were transported up here today, you were living in, what's called 10E?

A Correct.

Q And, you had been there for approximately two months?

A Yes.

Q Okay, And that is an isolation area?

A Yes.

Q You are housed by yourself in an isolation cell?

A Yes.

Q How many hours a day are you there?

A I'm there twenty-four hours a day, except for five days a week, when they take us outside. They put us in these big cages or pens about sixteen feet by thirty-five

feet, and when we are not, – on the other two days a week they take us to the showers.

Q All right. Now there's been testimony that there is a window that's built into your door?

A Yes.

Q Can you see a portion of the hallway from that?

A Yes.

Q Can you hear what's going on in the hallway from there?

A If people are screaming loud enough.

[169] Q Okay. You can't hear normal conversations of people going by?

A No. That little perforated screen he talked about must be built from the 1930's and it's totally clogged with dust, so there really isn't very much sound waves that goes through the screen, it's pretty well muffled. But, if you yell loud enough you can communicate with other prisoners through the vents and the sound will travel, if it's loud enough, through the steel door.

Q Is your cell clean?

A No, it's filthy. They say that we are allowed to clean it, but in reality, all that matters is them handcuffing you and making you get back, and then they push a mop, which is already dirty, because they use the same dirty mop water, and then we can mop and then push that back out. But, there is no way for us to sweep. So all the dust and all the dirt and all the filth, just stays in there

and all we can do is push a mop around, with dirty filthy mop water in it, which really doesn't accomplish anything.

Q Okay. Have you observed any insects or rodents in there?

A Yes. I have observed ants, and I've observed cockroaches.

Q Okay. Any rodents?

[170] A No, –

Q Okay.

A – not at that jail.

Q All right. You say you are able to hear loud noises out in the hall?

A Yes.

Q Okay. Well, there was testimony by Dr. Wolfson, that, I believe he is not aware of any physical abuse of inmates by staff. Have you witnessed any of that while you've been in 10?

A Yes, I've witnessed several brutalities, and beatings on numerous occasions. For example, –

Q Where did they take place?

A Okay, one of the first ones I witnessed, was – what they enjoy doing is putting in a very violent psychotic, – actually he's a Chippewa Indian named Rostoak, they put him in with a Jamaican with dreads named Ellis, a dread Jamaican, and as Ellis was being walked out handcuffed, Ellis said, "No, I don't want to go in there, I don't want to go in there with him, that guy is violent," and the guard

said, "You don't have a choice, you're going in there with him, whether you want to or not." And so, they put both of them in together and then when they took their handcuffs off of both of them, they were locked in this pen sixteen feet by [171] thirty-five feet. And then the guards all left the yard, and went inside. Well, as soon as they went inside the Chippewa Indian ran up to the Jamaican and smacked him in the head and tried to grab his cigarettes from him, and the Jamaican held onto his cigarettes and a fist fight ensued. And the Jamaican was really just trying to defend himself, but he was much bigger than the Indian and they kept fighting and fighting, as if two Roman, – ancient Roman gladiators fighting to the death, while all of us prisoners stood there horrified, screaming, "Guards, guards, please come back out. Please come back out". And they wouldn't come back out until the Indian had his scalp all open and blood was pouring everywhere. And, finally, they came out, and they dragged the Indian away and they beat down the dread Jamaican, named Ellis, and then they dragged, –

Q When you say "beat him down," how?

A Well, they rushed him into the back of the pen and kept hitting him 'til he fell down, because the Jamaican was upset screaming, "It wasn't my fault. It wasn't my fault," and they were all screaming and then they just knocked him down, and then they handcuffed him and chained him up and dragged him out. And, we were just all standing there looking at each other, you know like, "What the," – you know, I mean, you can imagine, it was [172] extreme violence. I'd never seen anything like this in my life. Where two people were put into a cage as though they were dogs, with the guards knowing that there was going to be a fight, I wouldn't even think that should be

legal for animals, to encourage them to be this way. But the guards were joking and laughing about it, and of course, we were talking about for at least two weeks after that happened, and there was the blood, wasn't even removed, blood stains are probably still there. What was your question again?

Q Were there any comments, immediately afterwards by the guards?

A Yes, they said, "Next time we're going to bring out coke and popcorn for all you prisoners to watch the entertainment".

Q All right. Now that was a fight between two inmates, –

A Yes.

Q – have you observed any inmates being brutalized by guards?

A Yes, I have. An inmate named Scott, who is also from Jamaica, was beaten by a guard named Evans, as he had his hands cuffed behind his back, as he was coming back from the showers, because Evans just said – oh he slipped and fell, and when your hands are cuffed [173] behind your back you've got no way to stop your fall. But, what was happening is, he beat him, he knocked him down, – he hit him, and knocked him down, and Scott was screaming, and Evans was screaming, and Evans kept kicking him and kicking him and kicking him, as Scott was trying to crawl into his cell to get away from the kicks. And, then as he was almost completely in his cell, but his leg and his foot was still hanging out, Officer Evans continuously slammed the steel door onto Scott's foot. And you can, – if you get his medical records, his treatment for

that foot injury will be documented. Also, I've observed other Mexican and, – I don't know if he's a Mexican or Cuban, but I know there was an inmate that for at least two weeks had a huge, like a hole, in his head that the doctor kept coming out everyday and treating, and I asked him, and he said that was a blow that he had received from one of the guards. Also, that same inmate, Ellis, he's been beaten coming back from the showers, too. They really hate Ellis, because Ellis is fighting taking the psychotropic drugs, he doesn't want to take it. And, so he's got his lawyer, that's appealing it to the courts right now. They really hate it, they do everything to make someone take it, to get out of there.

Q Has anyone come to you with any kind of a plan for [174] your being released from 10E, based on an improvement in what they deem as problems in your behavior?

A No. Dr. DeMier always told me that he wasn't the one keeping me in 10A, every time I talked to him, he said it was somebody else. When I asked anybody else, or he'd, – like the officers, the officers said, "It's not us keeping you in 10A, it's Dr. DeMier". Dr. DeMier would always say, "It's not me keeping you in 10A it's the officers". So, he would purposely try and make me think that other people were keeping me in there.

Q Okay, so there was nothing suggested as far as improvement in your behavior, that would result in your getting back in general population?

A No. Never.

Q Okay. Other, than the Competency Restoration Group, that Dr. DeMier testified to, have you received

anything else in the way of psychological or psychiatric counseling or treatment, since you've been there?

A No. The Competency Restoration Group was, to me, trying to instruct perhaps people with very low intelligence, or, if I may use an old phrase, mentally retarded people, so that they would know the difference between a prosecuting attorney and a judge. I know the difference between a prosecuting attorney and a judge, so I would sit there and sit there, and listen to this.

[175] Q Okay. I think we got an idea of what the class was like from Dr. DeMier. But other than that, there's been nothing else that's been afforded you or tried with you?

A No.

MR. LAWLESS: Okay, I don't have anything further.

THE COURT: Okay. Mr. Marcus.

MR. MARCUS: Good afternoon, Dr. Sell.

THE WITNESS: Good afternoon.

CROSS EXAMINATION

BY MR. MARCUS:

Q I just have a few questions for you. Has anybody physically abused you in this 10E unit?

A Not physically, but verbally.

Q Has anybody beat you?

A No.

Q So, the acts that you've described, that happened to this Jamaican and this, – as you characterized it, Chippewa, that's never happened to you?

A No.

Q Okay. Let's talk about nurse Goldberg, just a little bit.

A Yes sir.

Q Initially, Dr. Sell, you wanted her to be your rep in the hearing, and, –

[176] A That's correct.

Q – and for whatever reason, she couldn't do that?

A She agreed to be my representative, and we got started going on that and then the social worker came and told me that she had been transferred to a different ward altogether, and that she would no longer be available to work with me.

Q Okay. Now, did you feel Nurse Goldberg was your friend?

A Not a friend, but I felt that I could trust her. I wouldn't say a friend, but I would say that she was an acquaintance that I felt comfortable with.

Q And you testified on direct sir, that you believed that she was flirtatious with other prisoners?

A I wouldn't use maybe the word "flirtatious," so much as friendly. I would observe other prisoners talking to her for probably a half an hour, joking and laughing, and just passing the time.

Q Did any of the other female nurses have this type of demeanor, as Nurse Goldberg had?

A No.

Q So, as you perceive it, she is the only one that had this overly friendly demeanor?

A I never said it was "overly friendly".

Q Now, on direct examination, I believe your counsel [177] asked you if she was flirtatious, and you said, "Yes"?

A Yes, she was flirtatious, more so than the other nurses.

Q Okay.

A But I never said she was overly friendly.

Q Okay. Did you feel she was flirtatious with you?

A Well, I don't know if I would use the word flirtatious with me, but I think we did a lot of fun things together.

Q And did you feel because of this relationship, and the fun things you did, that you had more of a special relationship with her as opposed to any other nurse?

A No.

Q Now, I believe Mr. Lawless asked you if other patients called her by her first name, and I believe your answer was, "No," is that correct?

A That's correct.

Q Did you ever address her by her first name?

A There was one time when I addressed her by her first name, she said she didn't like it and I never addressed her by her first name again.

Q Did you ever tell the guards, or tell Nurse Goldberg, that you were in love with her?

A No sir.

Q Did you ever make the comment that "I didn't touch [178] her, but I would if she would have let me"?

A To who?

Q To either the guards or to the nurse, or to the psychologist?

A No. I might have said something to one of the guards once that I didn't touch her.

Q Did you ever follow that comment up with the following phrase, "I didn't touch her, but if she had asked me I would"?

A I may have said that if she wanted me to touch her, but she never wanted, – she never asked me to touch her, and I never did touch her.

Q Did you think there was some point in time where she might want you to touch her?

A No.

Q Why would you even raise that question, that you would touch her if she asked, you knew that was an inappropriate behavior within the institutional setting, correct?

A No, I did not. No one ever told me that it was inappropriate behavior for me to touch another person.

Q You mean it's okay within the institutional setting for you to have physical contact with the female nurses?

A No one ever said it was inappropriate for me to actually touch another human being within the [179] institution. I never did touch Nurse Goldberg, but I don't feel it would be inappropriate if we happened to touch.

Q Did you ever tell either a guard or a nurse or an inmate, that you were in love with her and you couldn't help yourself?

A No.

Q You never used that phrase, "I can't help myself"?

A No, Not in, – no.

Q And, just so I make sure I understand what you are saying, you don't feel it would be wrong to have physical contact with a female staff, because no one told you that it was wrong?

A What do you mean by "physical contact"?

Q Touching.

A You mean like if I were to shake her hand?

Q I'm not talking shaking hands.

A Well, that's what I interpret touching, as to actually, physically touch another person. What do you interpret touching as?

Q Let me clarify, –

A Yes, please do, because I don't think we have the same definition as to touch.

Q So, if in fact, you have, –

A Can we look it up in the dictionary and see what [180] the definition of touch is in the dictionary?

Q Dr. Sell, please, – please listen to the question, okay. Let me rephrase it if it will help you, all right. You indicated that you that you may have told another guard or somebody, that you didn't touch her, but if she had asked you to, or let you, you would have?

A If she wanted to take my pulse, I would have allowed her to take my pulse.

Q So that comment only was concerning medical needs, pulses, listening to your heart, –

A I don't think pulse is a medicine. Pulse is a touching or a palpation. If Nurse Goldberg, wanted to palpate me, which is a medical terminology, I would have let her. Is that what you are referring to? I don't understand what your question is, frankly.

Q Okay. I think you've answered it, –

A Touching to me is like when I'm doing dentistry on a person, I physically touch them, that is part of the healing arts. A doctor physically touching someone, a nurse physically touching someone, is this what you are inferring to.

Q I'm asking you what you thought.

A I thought that it would mean conformity with a nurse wanting to touch me or me touching a nurse so she could see if I was warm or not, in a medical sense.

[181] MR. MARCUS: Well then, you've answered my question. Thank you, that's all.

THE COURT: Thank you. Anything further?

MR. LAWLESS: No.

THE COURT: You may be excused, Dr. Sell. Thank you.

THE WITNESS: Thank you.

MR. LAWLESS: We don't have any further evidence, Judge.

THE COURT: Okay. What I'm going to do is probably take notice of the whole file.

MR. MARCUS: Pardon me?

THE COURT: I'll take notice of the whole file. Would you like me to do that?

MR. LAWLESS: I'd like to get a transcript of this if I have a post-hearing brief, if I could?

THE COURT: Yes, I think that would be a good idea. Why doesn't somebody order it.

MR. LAWLESS: I'll order it.

THE COURT: Okay. And I'll authorize it, if I have to. If you want to make it expedited we can do that. Whatever you want to do. Makes no difference.

MR. LAWLESS: Okay.

THE COURT: Whatever you want to order. I don't know if it counts against your budget, –

[182] MR. LAWLESS: Yes, it, does, we have to pay out of our budget for it now.

THE COURT: Okay. Well, whatever you want to do. I'm sure either one of you need to order it, so –

MR. MARCUS: We could split the cost.

THE COURT: Or I order it on my own. That would be an idea.

MR. MARCUS: We could work something out, I'm sure. I'd like to get a copy, also.

THE COURT: Okay. And I don't care if it's expedited or not.

MR. LAWLESS: Okay.

THE COURT: Fine.

MR. LAWLESS: Thank you, Judge.

MR. SHORT: What do we want to do then about, –

MR. LAWLESS: When we get it, I guess, –

MR. SHORT: – timing after it's received?

THE COURT: Well, I would like, – obviously, I'd like to have some post-trial briefs.

MR. SHORT: Should we just wait until received, and then, –

THE COURT: Why don't we wait until it's received and then you all, –

MR. MARCUS: Figure out, –

[183] THE COURT: Yeah. Or I'll contact you, or you can contact me.

MR. MARCUS: Thank you, your Honor.

MR. LAWLESS: Thanks, Judge.

THE COURT: We'll just it keep moving along, though, that I do want to do, all right. We'll be in recess, thank you.

(Temporary Recess at 2:10 p.m.)

I, DEBORAH CARTER, do certify that the foregoing is a correct transcript from the electronic sound recording in the proceedings in the matter of the United States of America versus Charles Sell.

11/10/99 /s/ Deborah Carter

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. CHARLES THOMAS SELL, Defendant.	)	No. 4:98CR177DJS 4:97CR290DJS (Consolidated) (Filed Aug. 9, 2000)

MEMORANDUM AND ORDER
OF THE UNITED STATES MAGISTRATE JUDGE

This matter is before the court on the government's motion to involuntarily medicate the defendant using anti-psychotic drugs. The government further requests that the defendant's period of commitment be extended while the defendant is involuntarily medicated. On September 29, 1999, the undersigned held a hearing on the motion. Based on this hearing as well as other matters detailed below, the undersigned makes the following findings of fact and conclusions:

Background and Findings of Fact

On May 16, 1997, defendant Charles Sell was charged in a complaint with making false representations in connection with the payment of health care services in violation of 18 U.S.C. § 1035(a)(2). On that same date, the defendant was arrested and afforded his initial appearance. On May 20, 1997, the government

filed a motion for psychiatric examination of the defendant to determine his competency to stand trial. The motion states that the defendant has a history of mental illness, and is described by his employees as irrational and prone to angry and violent outbursts. On May 20, 1997, a magistrate judge granted the motion and the defendant was sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri, for an evaluation.

On July 2, 1997, a psychiatric evaluation report was received from Springfield, and on July 15, 1997, a hearing was held to determine the defendant's competency to stand trial. At the hearing, the court, without objection, considered the psychiatric evaluation report from Springfield. The report concluded that the defendant was currently competent to stand trial, but that there was a possibility that the defendant could, in the future, develop a psychotic episode, and that his paranoid personality characteristics would color his relationship with his counsel. Based on the report, the judge found the defendant currently competent to stand trial. On July 30, 1997, an indictment was returned against the defendant and his wife charging them with fifty-six counts of mail fraud, six counts of medicaid fraud, and one count of money laundering.

Six months later, on January 22, 1998, a petition was filed alleging that the defendant violated his conditions of release by attempting to intimidate a witness. Based on this petition, a warrant was issued for the defendant's arrest. On January 23, 1998, the defendant was arrested and brought to a magistrate judge's courtroom for his initial appearance. At that point, the defendant was out of control, screaming, shouting, and

using racial epithets. Because of the defendant's out-of-control behavior and at the request of the U.S. Marshals Service, the judge attempted to conduct the initial appearance in the Marshal's secure area. As the proceeding commenced, Dr. Sell began screaming and shouting personal insults at the judge and, as the judge started to advise the defendant of his rights, the defendant spat directly in the judge's face. In the judge's words, the defendant appeared "totally out of control."

On January 26, 1998, a bond revocation hearing was held and shortly thereafter, the defendant's bond was revoked and he was ordered detained. One factor considered by the judge was the report of a psychiatrist who was seeing Dr. Sell as a part of Dr. Sell's conditions of release. The psychiatrist reported that, as of January 21, 1998, Dr. Sell's mental condition was worsening. He said that Dr. Sell was not sleeping at night because he was staying up guarding his doors because he was expecting the FBI to "come busting through the door." The psychiatrist said that while Dr. Sell was not an immediate danger, this status could change at any time and Dr. Sell could become a danger. He said Dr. Sell needed to be treated with anti-psychotic medications.

On April 23, 1998, the defendant was charged in a second indictment with one count of conspiring to murder a witness in his fraud case and conspiring to murder an FBI agent who was working on the case, four counts of attempting to murder two separate witnesses in the case, and two counts of attempting to murder an FBI agent.

During the next several months, this matter was set for trial on multiple occasions, but was continued at the

request of both parties. The defendant appealed at least two matters to the Court of Appeals during this time period. On February 10, 1999, the defendant filed a motion asking this court to hold a hearing and determine whether or not Dr. Sell was competent to proceed to trial in this matter. The motion stated that in the opinion of Dr. Sell's psychiatrist and psychologist, Dr. Sell was not currently competent to proceed to trial. On February 22, 1999, the undersigned granted the government's separate motion to have Dr. Sell examined at the Springfield Medical Center to aid in the determination of the defendant's competency to stand trial. On April 14, 1999, the undersigned held a hearing to determine Sell's competency. Based on the evidence presented at that hearing, and without objection from the defendant, the undersigned found that the defendant was presently suffering from a mental disease or defect rendering him mentally incompetent to stand trial, particularly finding that the defendant was not competent to assist properly in his defense.

On April 14, 1999, based on this finding, the undersigned determined that Dr. Sell was incompetent to stand trial, and ordered that Dr. Sell be hospitalized for treatment in the U.S. Medical Center for Federal Prisoners for a period not to exceed four months to determine whether there was a substantial probability that the defendant would attain the capacity to allow his trial to proceed.

In June, 1999, an administrative hearing regarding the involuntary administration of anti-psychotic medication was held at the U.S. Medical Center for Federal Prisoners. Pursuant to this court's order, defendant's counsel was allowed to participate in the hearing. In

July of 1999, based on findings made by the hearing officer, the involuntary administration of anti-psychotic medication was authorized by the institution.

On August 20, 1999, the undersigned granted defendant's motion for a judicial hearing to determine the propriety of the administration of anti-psychotic medication, and stayed the administration of the medication by the institution pending the hearing. The undersigned also granted the institution's request to grant a 120-day extension of his commitment to Springfield. As stated, the hearing was held on September 29, 1999. The evidence, as submitted at the hearing by the testimony of a psychiatrist and psychologist from the Springfield medical center, as well as the affidavit of the defendant's psychiatrist and other defense exhibits revealed the following:

Dr. Richart DeMier, Ph.D., is a staff psychologist at the Medical Center for Federal Prisoners, Springfield, Missouri, and has been so employed for approximately five years. Dr. DeMier is the staff psychologist primarily responsible for the diagnosis of Dr. Sell's illness and for the day-to-day treatment of Dr. Sell. He has been in at least weekly contact with Dr. Sell, both during his first admission to the hospital, and during his most recent commitment in April, 1999. In addition to very frequently seeing and talking to Dr. Sell, DeMier also receives frequent reports from the staff of the medical center who are in daily contact with the defendant.

Based on these interviews and other information, Dr. DeMier has concluded that Dr. Sell is suffering from delusional disorder of the persecutory type, a very serious and potentially dangerous psychosis. Dr. DeMier

also concluded that the defendant's judgment is very poor and becoming worse each day that he is not treated with anti-psychotic medications.

As evidence of this deterioration, in July, 1999, Sell formed an infatuation with a female nurse on the staff of the medical center. He told the nurse that she was very special to him, and that the nurse did not realize how much she meant to him. When told that it was inappropriate to talk to the nurse in this familiar manner, he did not stop the familiarity, and told the nurse and other staff members that he could not help himself, and that he could not stop this conduct. Although he did not touch the nurse, he said that he would do so if she asked him, and the nurse considered him to be a danger to her safety. He also told staff members that he could "smell" the nurse's presence. During this same time, the defendant also told DeMier that he was afraid to be transferred to a county jail because he was certain that the FBI was actively involved in a plan to have him murdered. He also told DeMier that DeMier would be ordered to release him from custody so he could go to Bosnia with his army reserve unit, as this was essential to the national security. He also told DeMier that DeMier would be personally called before Congress to explain his mishandling of Dr. Sell's case.

Because of Sell's specific focus on the nurse, his increasing personalization of the perceived murder plot by the FBI, his personalization of animosity toward DeMier along with the defendant's history of committing an assault on a federal judge, and the fact that the defendant was charged with conspiring to murder an FBI agent and two witnesses in his case, DeMier concluded at the September 29, 1999 hearing, that the

defendant was an immediate risk to commit violent acts, and was dangerous to himself and to others. DeMier said that because Sell believes that people (including the FBI and DeMier) are out to get him, given Sell's mental condition, Sell is likely to "protect himself" by harming people who have no intention of doing any harm to him. The fact that Sell's delusional beliefs have become more focused makes Sell an immediate risk of violence to himself or others.

Because of this danger, Sell is being held in the most secure area of the Springfield medical center, and is allowed out of his holding area only for short periods of time. Although this ameliorates the defendant's danger to himself and the staff, it does not eliminate this danger because the staff still must have contact with him.

DeMier also believes that, based on his training and experience, the only treatment that will improve Sell's condition is the use of anti-psychotic medications, because there is no other effective treatment for the illness. He further believes that if Sell does not receive anti-psychotic medication, his condition will continue to deteriorate. However, if anti-psychotic medications are administered, it is likely that the defendant will be restored to competency, and that the danger caused to the staff by Sell's condition will be greatly reduced.

DeMier has treated two patients in the recent past for delusional disorder with anti-psychotic medications, and both treatments were successful. One of the patients was restored to competency, and the other patient was greatly improved and rendered not dangerous to the extent that he was released from prison. DeMier also

believes that the benefits of using anti-psychotic medications greatly outweigh any risks, and that the use of these medications is the only way to render the defendant not dangerous and to restore him to competency. According to the medical literature, anti-psychotic medication is the treatment of choice for delusional disorder, and delusional disorder responds favorably to the use of anti-psychotic medications.

Dr. James Wolfson, M.D., is a staff psychiatrist at the Springfield medical center and is the consulting psychiatrist on Dr. Sell's case. Based on his interviews of Dr. Sell, and his review of the medical center's records, it is Wolfson's opinion that Sell is psychotic, and that the only way to treat Sell's condition is with anti-psychotic medications. Without this treatment, Wolfson believes that Sell's condition will continue to deteriorate. Further, based on Sell's history and conduct, Sell is currently dangerous, and anti-psychotic medications will greatly reduce the risk of violence by Dr. Sell, and will render him not dangerous.

Dr. Wolfson has treated 1,000 to 2,000 patients with anti-psychotic medications, and has achieved good results in a great majority of these cases. In addition to rendering Sell less dangerous, Wolfson believes that there is a good chance that Sell can be restored to competency by the use of anti-psychotic medications. In the recent past, Wolfson has used anti-psychotic medications on five patients with delusional disorder, and has been successful in restoring four of these patients to competency, an eighty per cent success rate.

Further, Wolfson vehemently disagrees with the defendant's psychiatrist, that anti-psychotic drugs are

not effective and should not be used in the treatment of delusional disorder. Wolfson says that the medical literature, his own experience, and the very experts relied on by the defendant's psychiatrist, show that anti-psychotic medications, when combined with psychotherapy, are effective in the treatment of delusional disorder. Further, even the defendant's psychiatrist agrees that anti-psychotic drugs are effective in the control of agitation and dangerousness in patients with delusional disorder.

According to Wolfson, there are three main side effects involved in using anti-psychotic drugs. The first is tartive dyskinesia and/or distonic reaction. This side effect causes a person to have involuntary body movements of various parts of the body. This is not a permanent side effect, and this condition can be ameliorated by the use of other medications along with anti-psychotic drugs, or by switching from one anti-psychotic medication to another anti-psychotic medication. The side effect is not life threatening, and as stated is not a permanent side effect, but will go away with the use of other medications or withdrawal of the medication.

Another side effect is that some patients are somewhat sedated by the medication. With newer drugs, this side effect occurs infrequently and can be alleviated by changing the dosage of the medication. Further, because one of the purposes of the medication is to allow patients to assist effectively in the preparation and defense of their cases, Wolfson uses medications that do not significantly sedate the defendant or impair the ability of the defendant to assist in his own defense.

According to Wolfson, the other major serious side effect from the medication is neuroleptic malignant carcinoma which can be fatal. Of the 1,000 to 2,000 patients Wolfson has medicated with anti-psychotic drugs, none have developed this syndrome, and Wolfson has seen this complication occur only twice during his career. According to the medical literature, this condition occurs in about 1 in 10,000 patients who take the medication. Further, Dr. Wolfson desires to medicate the defendant with newer drugs, which have a much lower side effect profile than older medications.

It is also Wolfson's opinion that the only way to treat Sell's condition is with the use of anti-psychotic drugs, and it would be irresponsible and wrong not to use these medications. Without these medications the defendant will continue to suffer from a catastrophic and debilitating illness, from which he is never likely to recover. For all of these reasons, Wolfson believes that the benefits of using the medication far outweigh any risk from the medication in any patient he would treat for this illness, whether or not the person was incarcerated or institutionalized in any way.

At the conclusion of the hearing, both the defendant and the government requested permission to delay briefing the issues presented at the hearing until after a transcript was prepared. After requests for more time to file the memoranda by both parties, the briefs were eventually filed before the court at the end of January, 2000. Almost simultaneously with the filing of these memoranda, on January 31, 2000, Sell's attorneys filed a motion for relief from involuntary commitment stating the he was being illegally held at Springfield beyond the time permitted by the statute, and requesting that he be

immediately released. Further, in partial response to this motion, the government filed a motion for the extension of Dr. Sell's commitment to Springfield on February 3, 2000.

On March 20, 2000, the U.S. Medical Center for Federal Prisoners wrote the court asking that Dr. Sell's commitment be extended. Included in the report is a report from Dr. DeMier on Sell's mental condition. The report states that Sell's condition has deteriorated to the extent that the risk of physical injury to the staff and to Dr. Sell has become greater because of Sell's increased volatility and paranoia. Dr. DeMier also states that Sell's infatuation with the nurse at the facility has worsened to the point that his thoughts about her have outweighed other issues that should be much more important to him. DeMier described Sell' behavior as volatile because it can change suddenly without any apparent reason. In summary, DeMier concludes as follows:

> Anti-psychotic medication remains the only effective treatment for his mental illness. Without the opportunity to treat the defendant, he will continue to suffer from a debilitating and catastrophic illness, and we are placed at increased, even inevitable, risk of harm to the defendant or those charged with his care.

He further states that the use of anti-psychotic medications will provide the defendant with a good chance of being restored to competency.

Conclusions

Based on the above facts, as well as the law stated below, the undersigned orders the involuntary medication of Dr. Sell. In the case of *Riggins v. Nevada*, 504 U.S. 127 (1992), the court stated as follows:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated and the district court had found that treatment with anti-psychotic medication was medically appropriate and considering less intrusive alternatives essential for the sake of Riggins' own safety and the safety of others.

504 U.S. 127, 135.

Further, in *United States v. Morgan*, 193 F.2d 252 (4th Cir. 1999), the court stated as follows in ordering the forced medication of a pretrial detainee because the detainee was a danger to himself and others:

> The fact remains, however, that the finding that treatment with anti-psychotic medication was necessary to render Morgan competent to stand trial was accompanied by a finding that such medication was necessary because he is dangerous to himself and to others at Springfield. Although Morgan provides us with no psychiatric evidence supporting a conclusion that the dangerousness finding was made arbitrarily, he essentially requests that we disregard that finding so that we may evaluate the constitutionality of permitting Springfield medical personnel to make the determination of whether to forcibly medicate him solely for

> the purpose of rendering him competent to stand trial. This we are unwilling to do. We realize that forcibly medicating a pretrial detainee on the basis that such treatment is necessary because he is dangerous to himself or others in the institutional setting might have the incidental effect of rendering him competent to stand trial. However, if such an occurrence would come to pass in the present matter, Morgan would not simply be thrust into the courtroom for trial without additional procedural protections. Rather, he would be statutorily entitled to have a district judge conduct a pretrial examination of his competency to stand trial in the context of an evidentiary hearing at which time he would be represented by counsel and permitted 'to testify, to present evidence, to subpoena witnesses on his own behalf, and to confront and cross examine witnesses who appear at that hearing.' Morgan could be brought to trial only if the government proved to the district judge by a preponderance of the evidence that Morgan was able to understand the nature and consequences of the proceedings against him and to assist properly in his defense . . . Assuming that the government succeeded in this regard, Morgan may be entitled to even further procedural protection should the government forcibly plan to medicate him at any point during trial. Specifically, due process would require the district judge make findings as to the need for and medical appropriateness of such medication during trial. The district judge might also ensure the medication posed no significant risk of altering or impairing Morgan's demeanor in a manner that would prejudice his

> capacity or willingness to either react to testimony at trial or to assist his counsel.

193 F.3d 252, 264.

In *Papantony v. Hedrick*, 215 F.3d 863 (8th Cir. 2000) (a civil case filed by a prisoner at the Springfield Medical Center which the Court of Appeals construed as a *Bivens* action for damages) the court ruled as follows in rejecting the claim:

> A government official is immune from a *Bivens* suit unless the official's conduct violates a clearly established constitutional right. In Papantony's case the right is far from clearly established. In fact, Papantony as a pretrial detainee likely has no substantive due process right not to be forcibly administered anti-psychotic drugs to render him competent to stand trial. *See Riggins v. Nevada*, 504 U.S. 127. Finally, although we reject any remedy for Papantony at this time, circumstances could change and anti-psychotic drugs might eventually render Papantony competent to stand trial. If that occurs, this decision will not foreclose a future argument by Papantony that forced medication during trial violates his right to a fair trial. *See generally United States v. Morgan*, 193 F.2d 252 (4th Cir. 1999).

Given the above law, the undersigned concludes that the government has made a substantial and very strong showing that Dr. Sell is a danger to himself and others at the institution in which he is currently incarcerated. In addition, the government has shown that anti-psychotic medication is the only way to render him less dangerous, and that the serious side effects of the medication will be ameliorated by newer drugs and/or

changing of the drugs. Further, the benefits to Dr. Sell of using the medication far outweigh any risks, the use of such medication is necessary, and a strong showing of the necessity to use this medication has been made by the government. In addition, as in *United States v. Morgan, supra*, an ancillary effect of the use of the medication, because Dr. Sell is dangerous, is that there is a substantial probability that Dr. Sell will be returned to competency.

In *United States v. Weston*, 206 F.3d 9 (D.C. Cir. 2000), the court held that even if a court finds that forced medication is necessary and essential to the defendant's safety and the safety of others, the court must also consider the need for the medication in restoring competency, and the effect of the medication on the defendant's ability to assist in his defense. In the case now at bar, the record reveals that anti-psychotic medication is the only way to render the defendant both not dangerous **and** to make him competent to stand trial. If Dr. Sell is not medicated, he will continue to suffer from a catastrophic and debilitating illness, will remain incompetent, and remain a danger. According to Dr. Wolfson, if the defendant is medicated and receives psychotherapy along with the medications, his delusions will diminish to the extent that they will no longer control his thinking and actions. Given this, Dr. Wolfson's opinion is that the defendant has a good chance of becoming competent and less dangerous. Because the defendant's delusions will no longer control or dominate his thoughts and actions, the undersigned concludes that if medicated, the defendant will be able to communicate with his counsel in a rational manner in order to assist in his defense. Further, Dr. Wolfson intends to

use atypical anti-psychotic drugs with a low side effect profile when medicating Dr. Sell. Dr. Wolfson also intends to avoid sedating Dr. Sell, because his purpose is to allow him to participate meaningfully in his trial. He likewise intends to avoid all other side effects to the maximum extent possible. Thus, the undersigned concludes that the standard required in *Weston, supra*, has been met in the case now at bar.

Based on the above, the undersigned concludes that the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted. There are no other less restrictive means by which this may be accomplished, including other medications, psychotherapy without the use of anti-psychotic medications, and locking down the defendant, all of which have either been attempted or considered. Therefore, the undersigned concludes that Dr. Sell must be involuntarily medicated with anti-psychotic medications.[1]

Based on the above facts and law, the undersigned grants the government's motion for extension of his commitment for a 120-day period of time, because there is a substantial probability that within such period of time, Dr. Sell will attain the capacity to permit the trial to

[1] The defendant cites *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998) as controlling in this matter. Although the undersigned believes that the government has met the standards required by *Brandon*, it solely involves the legality of the medication of a non-dangerous pretrial detainee unlike the case now at bar.

proceed if medicated. The undersigned further notes that because the defendant has (as is his absolute right) refused to take anti-psychotic medication, and explored all legal means possible to avoid taking the medication, Dr. Sell has not yet been treated with the only treatment which the undersigned has concluded will render him less dangerous and competent. Therefore, based on the above, the government's motion for extension of commitment is granted.

The defendant also alleges that he is being unlawfully held beyond the time authorized by the statute, and that it is unconstitutional to indefinitely commit him for purpose of rendering him competent. In *United States v. Kokoski*, 82 F.3d 411 (4th Cir. 1996), the court ruled that the defendant's right to due process was not violated by an 18-month commitment to obtain his competency. In so holding, the court stated as follows:

> He first argues that § 4241(d) limits the time he may be hospitalized to eight months . . . We reject this argument. We think 'an additional reasonable period of time' means some reasonable but statutorily undefined period of time. *United States v. Ecker*, 30 F.3d 966, 969 (8th Cir. 1994). Here we find that Kokoski's 18-month confinement was reasonable. Every report issued before the Butner staff declared Kokoski competent indicated he was likely to regain competency. The final six months of his confinement were necessary to challenge and clarify Butner's conclusion. In light of the district court's careful adherence to statutory procedures, we believe Kokoski's confinement was reasonable. *See id.* (confinement during seven competency evaluations spanning nearly four years not unreasonable).

82 F.3d 411, 1996 WL 181482. Further, in *United States v. Ecker*, 30 F.3d 966 (8th Cir. 1994), a case involving at least five competency commitments over a three and a half year period of time, the court stated as follows: "The overall determination of ultimate competency to stand trial can extend over a reasonable period." *Id.* at 970. Having considered the background and evidence, the Eighth Circuit held that there "was no clear violation of the statute in ordering each of the several competency evaluations nor an unreasonable overall delay in the proceedings under the circumstances." *Id.* at 970.

Based on the above law, the defendant's request for relief from involuntary commitment should be **denied**.

Therefore,

IT IS HEREBY ORDERED that the government may involuntarily medicate the defendant with anti-psychotic drugs consistent with this memorandum. It is also **ORDERED** that this portion of the court's order shall be stayed for fourteen (14) days to allow the defendant to appeal this portion of the order if he so desires. Any further stay must be granted by a United States District Judge or the United States Court of Appeals.

IT IS FURTHER ORDERED that the government's request for an extension of the defendant's commitment be **granted**, and that his commitment is ordered extended for a 120-day period of time effective as of the date of this order.

IT IS FURTHER ORDERED that defendant's request for relief from involuntary commitment should be **denied**.

IT IS FURTHER ORDERED that this Memorandum and Order supersedes the Interim Order entered by this court on July 28, 2000.

/s/ Terri I. Adelman
UNITED STATES MAGISTRATE JUDGE

Dated this 9th day of August, 2000.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
vs.	)	No. 4:98CR290-DJS
	)	4:98CR177-DJS
CHARLES THOMAS SELL,	)	
Defendant.	)	(Filed Apr. 4, 2001)

ORDER

Defendant is a pretrial detainee who has been found incompetent to stand trial and who is currently remanded for treatment to the United States Medical Center for Federal Prisoners at Springfield, Missouri ("USMC"). By order dated August 9, 2000, a United States Magistrate Judge granted the government's request for an order authorizing the involuntary administration of anti-psychotic drugs to defendant. On August 18, 2000, the magistrate judge denied defendant's motion seeking reconsideration of the August 9 order, a reopening of the September 29, 1999 hearing in the matter, and the production of certain evidence. The matter is now before the Court on defendant's appeal of the magistrate judge's denial of defendant's motion for reconsideration of the involuntary medication ruling. For reasons explained fully below, the Court here affirms the magistrate judge's ruling that substantive due process does not preclude the forcible administration of anti-psychotic medications to defendant in this case.

Pursuant to 28 U.S.C. § 636(b)(1)(A), defendant's motion concerning involuntary medication was referred to the magistrate judge for his consideration and ruling. Order of 7/30/99 [Doc. #323/#188]. Section § 636(b)(1)(A) provides that a district judge may "reconsider any pretrial matter under this subparagraph (A) where it has been shown that the magistrate's order is clearly erroneous or contrary to law." As indicated above, defendant asks this Court to reconsider the magistrate's denial of the motion to reconsider. In his motion to this Court, defendant characterizes the grounds for reconsideration as follows:

> (1) The Magistrate's findings of fact with regard to the side effects of antipsychotic drugs are squarely refuted by the relevant medical literature and by the testimony adduced at the hearing by both the Government and by Dr. Sell; (2) the Magistrate's finding that Dr. Sell is dangerous is clearly erroneous; (3) the Magistrate improperly based its findings of fact upon the Government's anecdotal evidence and upon communications the Government submitted to the Magistrate ex parte in a post-hearing letter; and (4) the Magistrate's conclusions fail to take into account the effect drugging will have on Dr. Sell's ability to receive a fair trial.

Motion [Doc. #372/#232], p.2 After reviewing the legal principles applicable to the issue of involuntary administration of drugs, the Court will address each of these assertions in turn.

Due Process and the Forcible Administration of Anti-Psychotic Drugs

Certain interests deemed sufficiently fundamental to human liberty are protected by the Due Process Clauses of the Fifth and Fourteenth Amendment. A liberty interest in this protected class cannot constitutionally be impinged by government action unless the infringement is narrowly tailored to serve a compelling state interest. *See, e.g., Reno v. Flores*, 507 U.S. 292, 301-02 (1993). In *Washington v. Harper*, 494 U.S. 210 (1990), the United States Supreme Court held that a prison inmate's interest in resisting involuntary administration of anti-psychotic drugs had Due Process protection. "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Id.* at 220; *see also United States v. Brandon*, 158 F.3d 947, 956-57 (6th Cir. 1998) [applying the strict scrutiny standard to issue of forcible medication of non-dangerous pretrial detainee].

Riggins v. Nevada, 504 U.S. 127 (1992), involved a pretrial detainee:

> Under *Harper*, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment affords at least as much protection to persons the State detains for trial . . . Thus, once Riggins moved to terminate administration of antipsychotic medication, the State became obligated to establish the need for [it] and the medical appropriateness of the drug.

Id. at 135 (internal citations omitted).[1] *Riggins* appears to identify two possibilities for the type of government interest sufficient to override the detainee's protected liberty interest, where medical appropriateness is also shown. These interests are the safety of the detainee and others and the detainee's restoration to competence:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with anti-psychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others . . . Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Id. at 135 (internal citations omitted).

The proceedings before the magistrate judge were based on the defendant's motion for a judicial hearing on the issue, rather than on a motion from the government which might have more clearly identified the legal and

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[1] The Court respectfully suggests that the Eight Circuit's per curium opinion in *Papantony v. Hedrick*, 215 F.3d 863, 865 (8th Cir. 2000), misspeaks when it characterizes *Riggins* as indicating that a pretrial detainee "likely has no substantive due process right not to be forcibly administered antipsychotic drugs to render him competent for trial."

factual basis on which the involuntary medication was sought. Both dangerousness and the need to restore defendant to competence are touched upon in the record, however, and the magistrate judge's determination that the forcible administration is permissible appears to be based on both rationales. Memorandum and Order of 8/9/00 [Doc. #367/#227], pp. 12-14. The magistrate judge found as follows:

> [T]he undersigned concludes that the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial on the very serious and violent offenses for which he now stands indicted. There are no other less restrictive means by which this may be accomplished, including other medications, psychotherapy without the use of anti-psychotic medications, and locking down the defendant, all of which have either been attempted or considered. Therefore, the undersigned concludes that Dr. Sell must be involuntarily medicated with anti-psychotic medications.

Id. at 14.[2]

[2] This portion of the ruling belies defendant's contention that the magistrate judge "wholly failed to address the question of whether or not medication is necessary to render Sell competent for trial," a contention that need not be further addressed. Def. Supplemental Memorandum in Support of Motion to Reconsider [Doc. #403/#262], p.5.

Side Effects and Effectiveness of Anti-Psychotic Drugs

Defendant first contends that the magistrate judge's findings of fact on the issue of side effects are erroneous. The magistrate judge's order reviews the evidence concerning three potential side effects: tardive dyskinesia, sedation, and neuroleptic malignant carcinoma. The magistrate judge found that "the serious side effects of the medication will be ameliorated by newer drugs and/or changing of the drugs," and that "the benefits to Dr. Sell of using the medication far outweigh any risks." Memorandum and Order of 8/9/00 [Doc. #367/#227], p.12. Tardive dyskinesia is identified as involuntary body movements. The magistrate judge's order indicates that this effect is not permanent and can be ameliorated by supplemental medications or, as necessary, a change in the anti-psychotic medication. *Id.* at 8. In his motion to this Court, defendant cites to the testimony of a government witness, clinical psychologist Richard DeMier, that the condition is permanent. Motion [Doc. #372/#232], p.9, *citing* Transcript of 9/29/99 Hearing [Doc. #341/#205], p.32.

In his reconsideration ruling of August 18, 2000, the magistrate judge indicated that even if tardive dyskinesia is a permanent effect, he would continue to conclude that "the potential benefit of treatment far outweighs any risk." Memorandum [Doc. #371/#230], p.1. Even under defendant's view of this disputed fact, then, the magistrate judge's conclusion is unaffected. That being the case, any error in his factual finding per se does not require reconsideration by this Court. Furthermore, having reviewed the record upon which the magistrate judge acted, this Court would concur in the conclusion that the medical benefits outweigh the medical risks, giving due weight to the range of seriousness of the various risks, to the prospects for

alleviating certain side effects with supplemental medication, and to the fact that a particular side effect may or may not occur in Dr. Sell.

Defendant also makes generalized arguments concerning the efficacy of anti-psychotic drugs. Having considered all the evidence of record before the magistrate judge, and acknowledging that there exist differences of opinion among practitioners in the field, including the experts relied upon by the parties, the Court cannot conclude that the magistrate judge clearly erred in determining that there is a significant potential medical benefit of treatment with anti-psychotics.[3] As is presumably characteristic in cases of delusions, Dr. Sell does not believe himself to be delusional and, not thinking his delusional beliefs are false, he is not persuaded his delusions require treatment. The Court's analysis begins with a sharply different factual premise, however, namely that Dr. Sell suffers from a serious delusional disorder, which currently significantly impairs and misleads his interpretation of reality and his reasoning. Arguments made on his behalf which neglect to take this into account are

[3] The Court notes that in his appeal to this Court, defendant cites to sources which were not of record before the magistrate judge, some of which could not have been, given their more recent vintage. These included an Indiana Law Review, *Postgraduate Medicine* (2000), and *American Journal of Psychiatry* (2000). The Court here acting as an appellate court of sorts, and given the applicable standard of review, the Court's consideration of this new evidence appears to be inappropriate. In any event, the Court notes that its conclusions concerning risk/benefit analysis and the efficacy or appropriateness of anti-psychotics in Dr. Sell's case would be unaffected by consideration of these sources.

therefore necessarily diminished in their persuasiveness and impact.

The principal basis for the finding of incompetency is the interference of defendant's delusional beliefs with this ability to assist in his defense. These are characterized by his own psychiatrist as "systematized persecutory delusions that he is the victim of a government plot to discredit his allegations about widespread illegal behavior by corrupt individuals to spread HIV and kill innocent civilians throughout the world." 9/28/00 Letter of Dr. Cloninger, attached to Def. Supplemental Memorandum in Support of Motion to Reconsider [Doc. #403/#262]. Defendant believes that this prosecution and the government's position as to his incompetence reflect an effort to cover up his knowledge of the government's culpability in the deaths of David Koresh and his followers in the Branch Dividian compound near Waco, Texas in 1993, knowledge defendant claims to have based on his experiences on Army Reserve duty in Texas at that time. Forensic Psychological Report [Sealed Doc. #304/#169], pp.5-6. Another example of defendant's delusional thinking is described in the testimony of defendant's treating clinician at the magistrate judge's evidentiary hearing:

> [W]hen the U.S. Military initially became involved in the Bosnia conflict, Dr. Sell stated that he expected the U.S. Military to come to our facility to secure his release so that he could go to Bosnia. When he was told that that was not likely to happen, he expressed some delusional beliefs that his presence in Bosnia was absolutely essential to the safety of our troops, and if he weren't permitted to go that would meant that it, to use his words—somebody wanted a lot of American boys dead.

Transcript [Doc. #341/#205], p.11. Risks of unpleasant or even dangerous side effects and the impact of anti-psychotic drugs on Dr. Sell's cognitive processes are counterbalanced by the substantial weight of his current impaired and incompetent state, despite Dr. Sell's protestations to the contrary.

Dangerousness

Defendant argues that the magistrate judge's finding that he is currently a danger to himself or others is clearly erroneous. The magistrate found:

> Because of Sell's specific focus on the nurse, his increasing personalization of the perceived murder plot by the FBI, his personalization of the animosity toward [prison psychologist] DeMier along with the defendant's history of committing an assault on a federal judge, and the fact that the defendant was charged with conspiring to murder an FBI agent and two witnesses in his case, DeMier concluded at the September 29, 1999 hearing that the defendant was an immediate risk to commit violent acts, and was dangerous to himself and to others. DeMier said that because Sell believes that people (including the FBI and DeMier) are out to get him, given Sell's mental condition, Sell is likely to "protect himself" by harming people who have no intention of doing any harm to him. The fact that Sell's delusional beliefs have become more focused makes Sell an immediate risk of violence to himself or others.

Memorandum and Order of 8/9/00 [Doc. #367/#227], p.6. The dangerous nature of the charges against Dr. Sell, involving a murder plot, is self-evident. The government

made little attempt to establish of record before Judge Adelman the particular circumstances of the incident which defendant spat in the face of another magistrate judge, but the incident does not appear to be in dispute. These considerations do not support a finding of current or immediate dangerousness in defendant's present setting, however.

The only evidence of record supporting the asserted personalization of hostility toward Dr. DeMier, defendant's treating clinician, is defendant's telling Dr. DeMier that he should be prepared to testify in Congress concerning his conduct in this case. Transcript, p.10. In testimony concerning a variety of delusional beliefs held by defendant, Dr. DeMier testified that defendant "continues to harbor beliefs that if he were moved to a County Jail, the FBI would have him killed." *Id.* at 11-12. Accepting as true the government's version of the facts concerning defendant's conduct with regard to the nurse, which defendant disputes, the conduct amounted to an inappropriate familiarity and even infatuation with the nurse, but the record does not support the conclusion that the conduct was sufficient to put the nurse in fear of violence from defendant.[4] Even if the trend in defendant's thoughts and feelings is described in Dr. DeMier's testimony and set forth above, and even if, as Dr. DeMier testified, this trend suggests an increased risk of violence, the risk is not shown to be particularly great or imminent.

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[4] This is particularly so because no testimony or other information from the nurse herself was submitted for the record.

The record does not indicate that defendant has posed a danger to himself or others during the period of his institutionalization at the USMC, and the statements and conduct relied upon for finding of dangerousness do not suggest a threat of violence to the staff.[5] Without more, this Court deems it clearly erroneous to conclude that defendant presents a danger to himself or others sufficient to constitute a compelling state interest outweighing his interest in refusing anti-psychotic medication. The Court's conclusion in this regard is based both on the relative weight of the facts evidenced in the record and what the Court regards as the appropriate legal standard for finding of dangerousness for the present purpose. The Court here makes explicit its view that the standard of dangerousness pertinent to the determination now before it concerns defendant's dangerousness *at this time* to himself and to those around him *in his institutional context*. The determination here made would not necessarily bear on any finding concerning defendant's dangerousness to himself, the public, or any other particular persons if released from an institutional setting.

The claim of dangerousness may also be a post hoc justification. Notice of the institutional medication hearing was given to defendant as early as April 28, 1999, just two weeks after he was found incompetent to stand trial and ordered hospitalized for treatment. *See* "Notice of Medication

[5] Defendant was transferred to a locked-down cell as a disciplinary measure after he allegedly disregarded the nurse's directive to leave the nurse's station, but has since been returned to an open ward. *See* Defendant's Update to Supplemental Memorandum [Doc. #405/#264] and Defendant's Second Update to Supplemental Memorandum [Doc. #408/#267].

Hearing and Advisement of Rights" form included in Addendum Exh. A to Def. Motion Regarding Involuntary Psychiatric Treatment and Medication [Doc. #322/#187]. The April 28, 1999 notice provided to defendant stated that the proposed treatment was "Antipsychotic medication" and that the reason for such treatment was to "Restore competency to stand trial." *Id.* Dangerousness in his prison setting was not a basis for the administrative decision to forcibly medicate defendant. *See* "Involuntary Medication Report" included in Addendum Exh. A to Def. Motion Regarding Involuntary Psychiatric Treatment and Medication [Doc. #322/#187]. Instead, the administrative determination was based on the conclusion that anti-psychotic drugs were medically necessary as treatment for defendant's delusional and possibly schizophrenic state.

Anecdotal Evidence and Ex Parte Materials

Defendant next contends that the officials of the USMC improperly communicated with the magistrate judge by letter on March 20, 2000, and that the ex parte materials should not have been considered by the magistrate judge to support a finding of dangerousness. This communication consists of a letter from the warden and a "Brief Hospitalization Summary and Request for Extension of Commitment" signed by Dr. DeMier, and appears to be intended as a 120-day report on defendant's hospitalization. Particularly in the context of these proceedings, where the issues concerning anti-psychotic medication are so highly contested, the letter and report should have been served by the USMC on counsel for both parties. In any event, given this Court's conclusion on the issue of dangerousness sufficient to outweigh defendant's liberty interest, the issue need not be further addressed.

The remainder of this point on appeal consists of argument with the sufficiency of the "anecdotal evidence" supporting the opinions of the government's witnesses, treating psychologist Dr. DeMier and consulting psychiatrist Dr. Wolfson, concerning the safety and efficacy of anti-psychotic medications. The Court has earlier expressed its view that the magistrate judge's findings on these issues were adequately supported by the record, and defendant's additional arguments do not disturb that view. To the extent that defendant argues he should have an opportunity to adduce expert testimony challenging DeMier's and Wolfson's conclusions, the argument is entirely unavailing. Defendant has had every opportunity to offer such testimony, at or in the substantial period of time since the evidentiary hearing held on September 29, 1999.

Defendant's Trial Rights

Finally, defendant argues that the forcible administration of anti-psychotic medication will adversely affect his ability to obtain a fair trial by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom and/or by rendering him unable or unwilling to assist counsel. If defendant's medication renders him unable or unwilling to assist counsel, an unfair trial will not occur. A showing that he is unable to assist properly in his defense would result in a continued finding that defendant is not be competent to stand trial.

That the effects of medication might prejudice the defense at trial is a serious issue, but not one which can preclude forcible medication based on the necessarily generalized manner in which the argument must be

presented at this time. The issue is, in effect, premature. Until defendant is treated with anti-psychotic medication, its effects on his demeanor cannot reasonably be assessed. In its appellate role, the Court is unpersuaded that the magistrate judge's conclusion in favor of forcible medication is the result of legal or factual error on the issue of medication's impact on defendant's trial rights.

In its capacity as the trial court in this case, the Court here states that if medication is administered and the defense presents argument and evidence concerning its adverse effect on Dr. Sell's ability to defend himself, the Court will give the issue careful consideration. The Court commends to the parties the careful treatment of the trial rights issue by Judge Sullivan of the United States District Court of the District of Columbia in his recent decision in the *Weston* case, on the basis of a substantially more complete record. *United States v. Weston*, ___ F. Supp.2d ___, 2001 WL 286406 at *15-*19, slip op. at pp.44-57 (D.D.C. March 6, 2001). As Judge Sullivan states:

> The Court will reassess, upon request, its determination regarding the prejudice to Weston's fair trial rights resulting from medication when testimony about the actual, not hypothetical, impact of the medication is available. The Court is confident that any such review will not come too late to prevent impairment of Weston's rights. However, since Weston's reaction to the medication is, at this point, unknown, by proceeding the medicate him, the government risks the possibility of forfeiting its right to bring Weston to trial. Nevertheless, the Court is reasonably confident, based on the persuasive expert testimony, that any prejudice that

might arise would occur with ample time for the Court to revisit these issues.

If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include informing the jurors that Weston is being administered mind-altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston's unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial.

Id. at *19, slip op. at 56-57.

Alternative Basis for Affirmance

The Court reverses the finding below that defendant's dangerousness is a sufficient basis to override his protected liberty interest in refusing anti-psychotic medication at this time. The Court may, however, affirm the magistrate judge on any ground supported by the record, and the Court concludes there is such an alternate ground in this case. *See Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 621 (8th Cir. 1998). As earlier noted, the magistrate judge concluded that the forcible administration of anti-psychotic medication was supported by the government's strong showing that such drugs "are the only way to render the defendant not dangerous *and competent to stand trial on the very serious and violent offenses for which he now stands indicted*" and that "[t]here are no other less restrictive means by which this may be accomplished." Memorandum

and Order of 8/9/00 [Doc. #367/#227], p. 14 (emphasis added). Under *Riggins*, the government's inability to "obtain an adjudication of [defendant's] guilt or innocence by using less intrusive means" may be a compelling interest which overrides defendant's liberty interest against taking the drugs.

This Court agrees with the magistrate judge that this is such a case. The interest in adjudication of the charges is less compelling in cases involving lesser offenses. Here, in addition to 63 counts involving mail fraud, Medicaid fraud and money laundering, defendant is charged with conspiring to kill, and attempting to kill, a witness and an FBI agent. The seriousness of these charges contributes greatly to the compelling strength of the government's interest in adjudicating defendant's guilt. *See United States v. Weston*, ___ F.Supp.2d ___, 2001 WL 286406 at *14, slip op. at pp. 42-43 (D.D.C. March 6, 2001).

In summary, the Court concludes that the record supports three findings: (1) that anti-psychotic drugs are medically appropriate for defendant, (2) that they represent the only viable hope of rendering defendant competent to stand trial, and (3) that the administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of defendant's guild or innocence of numerous and serious charges. These findings yield the conclusion that defendant's substantive due process rights do not preclude the involuntary administration of anti-psychotic medication.

Accordingly,

IT IS HEREBY ORDERED that defendant's motion to reconsider the magistrate judge's August 21, 2000 order [Doc. #372/#232] is denied.

IT IS FURTHER ORDERED that defendant's motion to reconsider and request for discharge from custody or for a hearing pursuant to 18 U.S.C. § 4246(e) [Doc. #407/#266] is denied.

IT IS FURTHER ORDERED that the magistrate judge's order permitting the involuntary administration of anti-psychotic medication to defendant Charles Sell is stayed for fourteen (14) days to permit defendant to take an appeal from this ruling. Any further stay must be granted by the United States Court of Appeals.

Dated this 4th day of April, 2001.

/s/ Donald J. Stohr
United States District
Judge

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282 F.3d 560

United States Court of Appeals,
Eighth Circuit.

UNITED STATES of America, Appellee,

v.

Charles Thomas SELL, Appellant,

Association of American Physicians & Surgeons, Inc. Amicus on Behalf of Appellant.

No. 01-1862.

Submitted: Oct. 15, 2001.

Filed: March 7, 2002.

Rehearing and Rehearing En Banc
Denied May 7, 2002.*

Lee T. Lawless, St. Louis, Missouri, argued, for appellant.

Dorothy L. McMurtry, Assistant U.S. Attorney, St. Louis, Missouri, argued (Raymond W. Gruender and Howard J. Marcus, on the brief), for appellee.

Before BOWMAN, HEANEY and BYE, Circuit Judges.

HEANEY, Circuit Judge.

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* Judges Loken, Murphy, Bye, and Riley would grant the petition for rehearing en banc. Judge McMillian took no part in the consideration of this case.

Appellant Dr. Charles Sell, D.D.S. is charged with health care fraud, attempted murder, conspiracy, and solicitation to commit violence. In this appeal, Sell challenges the district court's[1] determination that he may be involuntarily medicated with antipsychotic drugs for the sole purpose of rendering him competent for trial. We affirm.

I. Background

On May 16, 1997, Sell was charged in a federal criminal complaint with making false representations in connection with payments for health care services in violation of 18 U.S.C. § 1035(a)(2). The government alleged that Sell and his wife submitted false claims to Medicaid and private insurance companies for dental services not provided, including false documentation and bogus x-rays in support of these claims. On May 20, 1997, the government filed a motion for psychiatric examination of Sell to determine his competence to stand trial.[2] On May 20, 1997, a magistrate judge ordered that Sell be sent to the U.S. Medical Center for Federal Prisoners at Springfield, Missouri ("Springfield") for an evaluation. On July 15, 1997, after receiving a psychiatric evaluation from Springfield, the district court held that Sell was competent to stand trial. The report, which was accepted without objection, stated that Sell was currently competent to stand trial but that there was a possibility that he would

[1] The Honorable Donald J. Stohr, United States District Court for the Eastern District of Missouri.

[2] Sell has a history of mental illness.

develop a psychotic episode in the future. On July 30, 1997, an indictment was returned against Sell and his wife, charging them with fifty-six counts of mail fraud, six counts of medicaid fraud, and one count of money-laundering.

In August 1997, Sell was released on bond. On January 22, 1998, the government filed a bond revocation petition alleging that Sell had violated the conditions of his release by attempting to intimidate a witness. A warrant was issued for Sell's arrest and he was brought before a magistrate judge for an initial appearance. Sell's behavior at this appearance was out of control. He screamed, shouted, and used racial epithets. Nonetheless, the judge tried to proceed, but when she advised Sell of his rights, he leaned towards her and spit directly in her face.

On January 26, 1998, a bond revocation hearing was held, and shortly thereafter, the court ordered that Sell's bond be revoked and that he be detained. At this hearing, the court received evidence that Sell's mental condition was deteriorating. Sell was not sleeping at night because he expected the FBI to barge into his house. A psychiatrist reported that Sell soon could become a danger to himself and others.

On April 23, 1998, Sell was charged in a second indictment with conspiring and attempting to kill a witness and an FBI agent. The government contends that Sell and his wife asked a hit man to plot the murder of a former employee at his dental office who planned to testify against him on the fraud charges. The government also alleges that Sell plotted to kill the African-American FBI agent who had arrested him. The two indictments were joined.

During the next several months, the trial date was continued on a number of occasions at the request of both parties. On February 9, 1999, Sell's counsel filed a motion asking this court to hold a hearing to determine Sell's competency. The government filed a separate motion to have a government psychologist examine Sell. Both Sell's psychologist and the government psychologist diagnosed Sell with delusional disorder, persecutory type.[3]

On April 14, 1999, the district court held a hearing on Sell's competency. Upon consideration of the evidence, the court found that Sell was suffering from a mental disease or defect rendering him incompetent to assist properly in his defense, and thus incompetent to stand trial. The court ordered that Sell be hospitalized at Springfield for a reasonable period of time not to exceed four months to determine whether there was a substantial probability that Sell would attain the capacity to stand trial.

At Springfield, Sell was under the care of two clinicians, Dr. DeMier, the clinical psychiatrist, and Dr. Wolfson, the consulting psychiatrist. Both Dr. DeMier and Dr. Wolfson determined that Sell was in need of antipsychotic medication.[4] On June 9, 1999, an administrative hearing

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[3] Delusional disorder is characterized by the presence of one or more non-bizarre delusions that persist for at least one month. *Diagnostic and Statistical Manual of Mental Disorders IV* at 296. The delusions are generally plausible ideas that can conceivably occur in real life. *Id.* The persecutory subtype of delusional disorder is characterized by a person's belief that he is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long term goals. *Id.* at 298.

[4] Justice Kennedy described antipsychotic medications in his concurring opinion in *Riggins v. Nevada:*

(Continued on following page)

First introduced in the 1950's, antipsychotic drugs ... have wide acceptance in the psychiatric community as an effective treatment for psychotic thought disorders. *See American Psychiatric Press Textbook of Psychiatry* 770-774 (J. Talbott, R. Hales, & S. Yodofsky eds. 1988 (*Textbook of Psychiatry*)); Brief for American Psychiatric Association as Amicus Curiae 6-7. The medications restore normal thought processes by clearing hallucinations and delusions. *Textbook of Psychiatry* at 744.

Riggins v. Nevada, 504 U.S. 127, 141, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (Kennedy, J., concurring). In *Washington v. Harper,* the Supreme Court discussed the side effects associated with antipsychotic medications:

> The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. (Citation omitted). While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects. One such side effect identified by the trial court is acute dystonia, a severe involuntary spasm of the upper body, tongue, throat, or eyes. The trial court found that it may be treated and reversed within a few minutes through use of the medication Cogentin. Other side effects include akathesia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs. See Finding of Fact 9, App. to Pet. for Cert. B-7; Brief for American Psychological Association as Amicus Curiae 6-9. Tardive dyskinesia is a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face. See *Mills,* 457 U.S., at 293, n. 1, 102 S.Ct., at 2445, n. 1. The State, respondent, and amici sharply disagree about the frequency with which tardive dyskinesia occurs, its severity, and the medical profession's ability to treat, arrest, or reverse the condition. A fair reading of the evidence, however, suggests that the proportion of patients treated with antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%. According to the American Psychiatric Association, studies of the condition indicate that

(Continued on following page)

was held before a medical hearing officer. Dr. DeMier and Dr. Wolfson testified in favor of using antipsychotic medication in the treatment of Sell, and testified that it was the only way he could be restored to competency. Sell proffered the affidavit of his psychiatrist, Dr. Cloninger, who asserted that he did not think Sell would respond well to medication. Cloninger Aff. ¶¶ 8, 17. Sell also called a number of witnesses and testified that he did not want to take antipsychotic medication and have his chemistry altered. The medical hearing officer concluded that antipsychotic medication was the treatment of choice. This finding was based on the fact that his delusional thinking could make him dangerous and that no other drug could treat his delusional symptoms. Dr. Sell filed an administrative appeal that was denied. The Medical Center delayed the administration of the medication to give Sell the opportunity to seek review by the district court.

On September 29, 1999, a United States Magistrate Judge conducted a full judicial hearing. At that hearing, the Government called two witnesses, Dr. DeMier and Dr. Wolfson. They testified that Sell was in need of antipsychotic medication, that his condition would continue to deteriorate without it, that his behavior could be dangerous, and that antipsychotic medication was likely to restore him to competency. On August 9, 2000, the magistrate entered

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60% of tardive dyskinesia is mild or minimal in effect, and about 10% may be characterized as severe. Brief for American Psychiatric Association et al. as Amici Curiae 14-16, and n. 12; see also Brief for American Psychological Association as Amicus Curiae 8.

Washington v. Harper, 494 U.S. 210, 229-30, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990).

an order finding that Sell posed a danger to himself and others. *United States v. Sell,* No. 4:98CR177, (E.D.Mo. Aug. 9, 2000) (order granting government's motion to involuntarily medicate defendant). Based on this finding, the magistrate authorized the government to forcibly medicate Sell with antipsychotic medication.

In April 2001, the district court reversed the magistrate's finding that Sell posed a danger to himself and others, noting that the evidence in the record was insufficient to support such a finding. Despite this reversal, the district court affirmed the magistrate's order, holding that the Government's interest in restoring Sell to competency so that he can stand trial was alone sufficient to warrant forcible medication.

Sell appeals this decision and asks this court to decide whether the district court erred in holding that he could be forcibly injected with antipsychotic drugs for the sole purpose of restoring his competency to stand trial. Sell also asks us to examine whether: (1) the district court applied the correct standard of review; (2) whether the district court properly considered his Sixth Amendment right to a fair trial, and (3) whether the government has proven by clear and convincing evidence that the medication is medically appropriate and that the medication has a reasonable probability of restoring his competency. The Government argues that the district court did not err on these grounds. It further argues that the district court's finding that Sell was not dangerous was erroneous and that Sell's dangerousness provides an alternate ground for affirmance in this case.

II. Discussion

A. Sell's Dangerousness to Himself and Others.

First, we consider the government's claim that the district court erred in overturning the magistrate's determination that Sell is dangerous. We review the district court's determination of questions of fact under the clearly erroneous standard. *See United States v. Kissinger,* 986 F.2d 1244, 1246 (8th Cir.1993). The government argues that the district court did not give adequate weight to Sell's *potential* to be a danger to himself or others. The district court noted, however, that Sell's inappropriate behavior at Springfield amounted at most to an "inappropriate familiarity and even infatuation" with a nurse. Upon review, we agree that the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center. The district court properly reversed the magistrate's finding.

B. Forcible Administration of Antipsychotic Drugs to Restore Competency

Next, we consider the question of whether the district court erred in holding that a pretrial detainee may be forcibly injected with antipsychotic medication for the sole purpose of rendering him competent to stand trial. This is an issue of first impression for this court. *Cf. Papantony v. Hedrick,* 215 F.3d 863, 865 (8th Cir.2000) (holding that in the context of a *Bivens* action, there is no clearly established right of a pre-trial detainee not to be forcibly administered antipsychotic drugs for the sole purpose of rendering him competent for trial). In *Washington v. Harper,* the Supreme Court recognized that individuals possess "a significant liberty interest in avoiding unwanted

administration of antipsychotic drugs." 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990); *cf. United States v. Weston,* 255 F.3d 873, 876 (D.C.Cir.2001) (citations omitted) ("The due process liberty interest in avoiding unwanted antipsychotic medication may be 'significant,' but it is not absolute."). In *Harper,* a convicted prison inmate claimed that the State of Washington violated his due process rights by administering antipsychotic drugs against his will. 494 U.S. at 217, 110 S.Ct. 1028. The Court acknowledged that Harper had a liberty interest in avoiding unwanted medication but held that the "Due Process Clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if [the inmate] is dangerous to himself or others and the treatment is in [the inmate's] medical interest." *Id.* at 211, 110 S.Ct. 1028.

In *Riggins v. Nevada,* the Court applied its *Harper* analysis to the issue of whether a pre-trial detainee may be forcibly injected with antipsychotic medication for the purpose of rendering him competent for trial. 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992). In *Riggins,* a pre-trial detainee was forcibly administered the antipsychotic drug Mellaril after a Nevada district court denied the detainee's pre-trial motion to terminate the medication with a one-page order that gave no indication as to the court's rationale. *See id.* at 130-31, 112 S.Ct. 1810. A jury convicted Riggins,[5] and he appealed, arguing that the forced administration of Mellaril denied him the ability to assist in his own defense and prejudicially affected his

[5] At trial, Riggins unsuccessfully presented an insanity defense and was convicted of murder and sentenced to death.

attitude, appearance and demeanor at trial. *See id.* at 131, 112 S.Ct. 1810. Riggins further argued that the prejudice was not justified because the state did not demonstrate a need to administer the drug, nor did it explore alternative treatments. The Supreme Court agreed, and held that Riggins's Fourteenth Amendment rights had been violated because the Nevada court did not acknowledge the detainee's liberty interest in freedom from unwanted medication, make any findings on the need for forced medication, and make findings on reasonable alternatives to antipsychotic medication. *See id.* at 136-37, 112 S.Ct. 1810. The Court also noted that forcible administration of antipsychotic drugs may have interfered with Riggins's Sixth Amendment right to a fair trial. *See id.* The Court, therefore, reversed and remanded the case.

The Supreme Court did not have the opportunity to determine when involuntary medication could be used on a pre-trial detainee because the Nevada court offered the accused almost no protection against involuntary medication. The Supreme Court did note, however, that:

> Under *Harper,* forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment guarantees at least as much protection to persons the state detains for trial. (Citation omitted).
>
> . . . Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the district court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others. (Citation omitted). Similarly, the state might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Id. at 135, 112 S.Ct. 1810.

Based on this language, we conclude that subject to the limitations outlined below, the government may forcibly administer antipsychotic medication for the sole purpose of rendering a pre-trial detainee competent to stand trial without violating the accused's due process rights.

C. The Standard of Review for Forcible Administration of Antipsychotic Drugs.

We now consider Sell's claim that the district court employed the wrong standard of review to determine whether forced administration of medication is appropriate in this case. Sell encourages us to adopt strict scrutiny, but the Supreme Court declined to adopt such a standard in *Riggins. See Riggins,* 504 U.S. at 136, 112 S.Ct. 1810.[6] Based on the Supreme Court's decisions in *Riggins* and *Harper,* and the decisions of our sister courts,[7] we hold that

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[6] The court stated: "We have no occasion to finally prescribe such substantive standards . . . since the District Court allowed administration of Mellaril to continue without making any findings about reasonable alternatives." *Riggins,* 504 U.S. at 136, 112 S.Ct. 1810.

[7] Other courts have come to contradictory conclusions on what substantive standards are necessary to satisfy a pretrial detainee's due process rights. The Sixth Circuit held that courts must apply the strict scrutiny standard when the state wishes to forcibly medicate a non-dangerous pre-trial detainee. *See United States v. Brandon,* 158 F.3d

(Continued on following page)

the government must meet the following test in order for the government to forcibly medicate an individual. First, the government must present an essential state interest that outweighs the individual's interest in remaining free from medication. *See Riggins,* 504 U.S. at 135, 112 S.Ct.

947, 960 (6th Cir.1998). The D.C. Circuit interpreted *Riggins* to require "heightened scrutiny" that takes into consideration the severity of infringement that antipsychotic drugs impose on an individual's liberty interest, the need to find an essential state policy that provides an overriding justification for forced medication, and a requirement to consider less intrusive alternatives. *See United States v. Weston,* 255 F.3d 873, 880 (D.C.Cir.2001). Similarly, the Southern District of California refused to adopt a strict scrutiny standard. Rather, it stated that the government must meet the following standard:

> First, the government must demonstrate that "administration of anti-psychotic drugs is necessary to accomplish an essential state policy." (Citation omitted). Second, the government must show that "there is a sound medical basis for treatment with anti-psychotic medication." (Citation omitted). In making this showing, the government may provide "medical testimony regarding [Defendant's] mental illness and its symptoms as well as the effects that anti-psychotic medication will have, both beneficial and harmful, on [Defendant's] physical and mental health." Third, and most importantly, the government must establish "that there is no significant risk that the medication will alter in any material way the defendant's capacity or willingness to react to testimony at trial or assist counsel." (Citation omitted). [T]he government must establish these elements by clear and convincing evidence.

United States v. Sanchez-Hurtado, 90 F.Supp.2d 1049, 1055 (S.D.Cal.1999). Like our sister courts, we believe that we must apply some sort of heightened standard of review, but unlike the Sixth Circuit, we do not adopt the strict scrutiny standard. *See e.g. Weston,* 255 F.3d at 888 (noting that the Supreme Court denied adopting a strict scrutiny test in *Riggins* but also appeared not to apply a reasonableness test or its various analogues: arbitrary and capricious, rational basis or exercise of professional judgment).

1810 (noting that the government must prove an overriding state interest). Second, the government must prove that there is no less intrusive way of fulfilling its essential interest. *See id.* Third, the government must prove by clear and convincing evidence that the medication is medically appropriate. *See id.* Medication is medically appropriate if: (1) it is likely to render the patient competent, *see Weston,* 255 F.3d at 876; (2) the likelihood and gravity of side effects do not overwhelm its benefits, *see id.;* and (3) it is in the best medical interests of the patient. *See Harper,* 494 U.S. at 227, 110 S.Ct. 1028 (noting that the court should consider the petitioner's medical interest). The district court did not explicitly apply this test, so we review the district court in light of the standards we have set forth.

The first question, therefore, is whether the district court erred by holding that the government's interest in bringing Sell to trial is sufficient to outweigh Sell's interest in refusing medication. This is a mixed question of law and fact, so we review the district court's finding de novo. *See Boysiewick v. Schriro,* 179 F.3d 616, 619 (8th Cir. 1999). To make this determination, we must weigh the government's interest in rendering Sell competent against Sell's interest in refusing unwanted medication.

The government has an essential interest in bringing a defendant to trial. *See Illinois v. Allen,* 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring) ("Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and a prerequisite to social justice and peace."). Not all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious. *See United States v. Brandon,* 158 F.3d 947, 961 (6th Cir. 1998). Here,

the sixty-two charges of fraud and the single charge of money-laundering are serious, a fact not denied by the defendant.[8] Despite Sell's significant liberty interest in refusing antipsychotic medication, in view of the seriousness of the charges, we believe that the government's interest in restoring his competency so that he may be brought to trial is paramount.[9]

The second part of our analysis is whether the district court erred in finding that there were no less intrusive means by which the government may achieve its essential interest. *See Riggins,* 504 U.S. at 135, 112 S.Ct. 1810 (noting that the government must prove that there is no less intrusive means). The government may not constitutionally bring an incompetent defendant to trial, *see Pate v. Robinson,* 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed.2d 815 (1966), so the only way the government may try Sell is by restoring his competency. Both Dr. Wolfson and Dr. DeMier testified that antipsychotic medication is the most effective treatment for delusional disorder and that it is the only way Sell could be restored to competency. *See* Transcript of Evidentiary Hr'g, Sept. 29, 1999 at 21, 75-78. Even Dr. Cloninger, who submitted an affidavit on behalf

[8] Although Sell is also charged with conspiring to murder an FBI officer and a witness, we base our reasoning solely on the seriousness of the fraud charges. It is possible that Sell's threats after his first indictment were a manifestation of his delusional disorder and we decline to make a determination about whether those charges suffice to involuntarily medicate him.

[9] We note that the government's interest in preserving a scheme of ordered liberty can only be achieved if a defendant is competent at trial. If the medication does not render Sell competent, his trial cannot proceed. *See infra* Part II.D.

of Sell and stated that antipsychotic drugs are not a proven treatment, did not suggest any alternative means of restoring competency. *See generally* Cloninger Aff. Based on this evidence, we believe that the district court correctly concluded that there were no less intrusive means.

Third, we must determine whether the evidence supports the district court's conclusion that antipsychotic medication is medically appropriate for Sell's treatment. We review the district court's findings of fact under the clearly erroneous standard. *See Love v. M.D. Reed,* 216 F.3d 682, 687 (8th Cir. 2000). Whether a proposed action is medically appropriate depends on the judgment of medical professionals. *See Harper,* 494 U.S. at 231, 233-34, 110 S.Ct. 1028. At the hearing before the Magistrate Judge, the government presented testimony from Dr. DeMier and Dr. Wolfson. Dr. DeMier, Sell's treating psychologist, testified that antipsychotic medication is the only treatment that has been shown to be effective in treating delusional disorder and it is the only treatment that could restore Sell to competency. He also stated that he has treated two patients suffering from delusional disorder with antipsychotic medication. Of the two, one was restored to clinical competency; the other patient improved, but did not regain competency.[10] Dr. DeMier also stated that antipsychotic medications have "potentially significant side effects, but there's also potentially, very significant recovery from symptoms."

[10] The patient who was successfully treated was given Haldol, a typical antipsychotic drug. The patient who was not restored to competency received Olanzapine, an atypical antipsychotic drug.

Dr. Wolfson, the staff psychiatrist who works as a consultant on Sell's case, also recommended that Sell be treated with antipsychotic drugs. Dr. Wolfson has treated seven patients with delusional disorder but only four for the purpose of restoring competency.[11] Dr. Wolfson reported that all seven benefitted clinically from antipsychotic medication and of the four who were treated for restoration of competency, three regained competency. Dr. Wolfson testified that the medical literature indicated that patients with delusional disorder respond less to medication than patients with other illnesses, but he stated that he doubts the accuracy of that conclusion and noted that the literature shows favorable results in many cases.[12] Dr. Wolfson admitted that there are both harmful and unpleasant side effects to antipsychotic drugs; these include sedation, neuroleptic malignant syndrome, which is rare but fatal,[13] and tardive dyskinesia and/or dystonic reaction, which causes a person to have involuntary movements of various parts of the body. Dr. Wolfson also stated, however, that the existence and/or degree of side effects could be controlled by changes in the doses and type of medication

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[11] He treated one of the patients twice. This patient was restored to competency, relapsed, then restored a second time.

[12] Dr. Wolfson explained that:

> First, the delusions stop expanding. . . . It's even conceivable that some delusional material may regress. . . . [O]ur first goal [is] to diminish the impact on . . . actions and . . . judgment of the illness. Second, [is] to minimize the expansion of the delusional system. . . . [I]t's typically been my experience [that this is] accomplished with other patients.

Transcript of Evidentiary Hr'g, Sept. 29, 1999 at 137.

[13] Dr. Wolfson testified that the incidence of this side-effect is one in ten thousand cases.

being used. He testified that the new generation of atypical antipsychotic drugs, such as Pimozide, have more benign side effects than the older typical antipsychotic drugs, such as Haldol. Dr. Wolfson admitted, however, that the atypical drugs can only be administered orally, and therefore cannot be used to forcibly drug uncooperative patients.

To combat this testimony, Sell presented the affidavit of Dr. Cloninger. Dr. Cloninger stated that "there is no evidence that [antipsychotic medications] are beneficial for patients with Delusional Disorder." Cloninger Aff. at 8. Dr. Cloninger admitted that antipsychotic drugs are often beneficial in treating schizophrenia but maintained that they do not provide the same benefit in the treatment of delusional disorder. Dr. Cloninger attached to his affidavit an excerpt from the American Psychiatric Press Textbook of Psychiatry. That text notes that there is a disagreement between experts on the effectiveness of treating delusional disorders with antipsychotic medication, but it also states that the medication may be useful, particularly for accompanying anxiety, agitation, and psychosis. Donald W. Black et al., *Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders,* in *Textbook of Psychiatry* (John A. Talbott et al. eds.) 1988. Dr. Cloninger was not able to recommend a less intrusive alternative to restore Sell to competency; rather, he suggested that treatment be limited to basic support and voluntary symptomatic treatment, and that such treatment also include access to exercise and reading material. *See* Cloninger Aff. ¶¶ 18-19.

In addition, Sell also presented the court with a report from the Federal Bureau of Prisons Institutional Metropolitan Correctional Center ("MCC") in which Dr. Daniel Greenstein, the forensic psychologist at MCC, stated that

delusional disorders do not typically respond to medication or psychotherapy.

Based on the totality of this evidence, Sell argues that the district court was clearly erroneous in finding that antipsychotic medication was medically appropriate. He contends that the district court erred by basing its finding, in part, on testimony that atypical antipsychotic medications have more benign side effects, because atypical drugs can only be administered orally, thus they cannot be given involuntarily. Sell also argues that the government did not prove that the medication has a reasonable probability of restoring competency. Finally, Sell argues that the court erred in finding medical appropriateness when the government failed to disclose which medication it would use.[14] Sell posits that without knowing which drugs would be administered, he was incapable of making anything more than a generalized argument. *See United States v. Sell*, No. 4:98CR177 at 7 (April 4, 2001) (upholding Magistrate's order allowing the involuntarily medication of Sell and stating that Sell's arguments against medication were generalized).

We disagree with these assertions. We acknowledge that there is a difference of opinion on the efficacy of using antipsychotic drugs to treat delusional disorder, but we do not believe that the district court committed clear error in finding that the government proved medical appropriateness by clear and convincing evidence. First, the government

[14] Dr. Wolfson stated that he did not want to be pinned down to a single drug because he hoped to leave part of the choice up to Sell. He recommended that the drugs Quetiapine or Olanzapine be used.

presented evidence that the medication can reasonably be expected to minimize Sell's delusions and render him competent for trial. Dr. DeMier has a 50% success rate and Dr. Wolfson has a 75% success rate in restoring competency to patients with delusional disorders. Moreover, the medication improved the condition of all the patients they treated, whether or not they were restored to competency. Dr. Wolfson testified about how the medication works, stating that the medication should reduce the impact of the delusion on Sell's thought process. Although we cannot say with 100% certainty whether Sell will regain competency with his treatment, the district court did not clearly err in finding a sufficient likelihood that antipsychotic medication will restore Sell's competence.

Second, the government proved that the side-effects produced by the medication could be minimized through careful treatment and changing medications and dosages. Although Dr. Wolfson did not name a specific medication, he did name the two he would most likely use. Therefore, we reject Sell's contention that he was not given the opportunity to make specific objections to specific drugs. Furthermore, we reject Sell's argument that the court erred in basing its opinion in part on the availability of atypical antipsychotic drugs which can only be administered orally. The availability of the atypical medications was not determinative to the district court's findings, and the evidence supports the conclusion that the doctors treating Sell will be able to reduce the incidence of unpleasant and harmful side-effects produced by typical antipsychotic medication as well.

Finally, the district court appropriately considered Sell's medical interest. The court noted that Sell's delusions interfere with his ability to make sound judgments

about his life and his treatment, and that his disorder currently impairs and misleads his interpretation of reality and his reasoning. The government presented evidence that antipsychotic medication is commonly used to help reduce delusions and their impact on an individual's life, and the court found that these benefits outweighed the risks associated with antipsychotic drugs.

The district court did not err in applying the wrong standard of review. As required, the court found that the government has an essential interest in adjudicating the serious charges against Sell. The court found that involuntary medication is the only way for the government to achieve its interest in fairly trying Sell and found that the medication is medically appropriate for him. The government proved these elements by clear and convincing evidence. Therefore, we find no reversible error in the standard of review employed by the district court.

We note, however, that this is a limited holding. We do not believe this standard will be met in all circumstances in which the government wishes to restore competence. Furthermore, we note that an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution. *See, e.g., Singleton v. Norris,* 267 F.3d 859 (8th Cir. 2001), *vacated and reh'g en banc granted* (Dec. 5, 2001). Therefore, our holding must be read narrowly.

D. Sell's Sixth Amendment Rights

Finally, we consider whether the district court properly considered Sell's Sixth Amendment right to a fair trial when it ordered the forcible medication. The district court held that Sell's Sixth Amendment claim was premature

because the effects of the medication on his competency to assist counsel and on his demeanor could properly be considered after medication. We note that before forcibly medicating an accused, there must be evidence that he will be able to participate in a fair trial. *See Brandon,* 158 F.3d at 960. That burden was met in this case. First, the magistrate found that the evidence indicated that Sell would be able to participate meaningfully in his trial while he is under the influence of the medication. *See United States v. Sell,* 4:98CR177 at 13 (E.D.Mo. Aug. 9, 2000). Also, the magistrate found that the medication would allow him to communicate with his counsel in a rational manner. *See id.* The magistrate further noted that Dr. Wolfson intends to use drugs with a low side-effect profile, to change drugs and dosages based on the side-effects Sell experiences, and above all, to avoid sedation. *See id.* The district court affirmed these findings. *See generally United States v. Sell,* 4:98CR177 at 5-9 (E.D.Mo. Apr. 4, 2001).

We find that the medical evidence presented indicated a reasonable probability that Sell will fairly be able to participate in his trial. As a result, we believe that the effects of the medication on Sell's competency and demeanor may properly be considered once the medication is administered. The district court noted its willingness to reexamine Sell's Sixth Amendment claim after the medication regimen has begun. *See id.* at 15. The evidence offered, that the drugs should not interfere with Sell's right to a fair trial, as well as post-medication procedures that ensure he will not be tried unfairly, are sufficient to protect Sell. There is no reversible error.

III. Conclusion

Having found no reversible errors, we affirm the district court's determination that Sell may be involuntarily medicated for the purpose of rendering him competent to stand trial.

BYE, Circuit Judge, dissenting.

Unlike the majority, I would apply the strict scrutiny standard of review for the reasons enunciated by the Sixth Circuit in *United States v. Brandon,* 158 F.3d 947, 956-61 (6th Cir. 1998). But even under the majority's three-part test, the charges against Dr. Sell are not sufficiently serious to forcibly inject him with antipsychotic drugs on the chance it will make him competent to stand trial. I therefore respectfully dissent.

The first part of the majority's test requires the government to demonstrate an essential interest that outweighs his interest in remaining free from medication. *Ante* at 567. The majority perfunctorily concludes the government's interest in prosecuting the defendant for sixty-two counts of fraud and one count of money laundering qualifies as an essential interest that trumps Dr. Sell's significant liberty interest in refusing antipsychotic medication. I strongly disagree.

While the government possesses an interest in bringing a defendant to trial, *ante* at 568, I do not believe every charge is sufficient to justify forcible medication of a defendant. *See Riggins v. Nevada,* 504 U.S. 127, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (stating the government *might* be able to medicate a defendant involuntarily if "it could not obtain an adjudication of [his] guilt or innocence by using less intrusive means") (emphasis added). It is helpful to compare two recent decisions confronting this precise issue. In *United States v. Weston,* 255 F.3d 873 (D.C.Cir.2001), the Court of Appeals for the District of Columbia recognized the government's interest in adjudicating those who violate the law. In that case, Russell Weston entered the Capitol building and shot three police officers, killing two of them. A grand jury indicted Weston on two counts of *murder,* and one count of *attempted murder* of a federal law officer, in addition to three counts of *using a firearm in a crime of violence.* *Weston* explained that "[t]he government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business." 255 F.3d at 881. *Weston* also noted "[t]he statutory sentences for the crimes Weston is accused of committing – *life in prison and death* – reflect the intensity of the government's interest in bringing those suspected of such crimes to trial." *Id.* (emphasis added).

Weston typifies the case where the government's interest is paramount because the charges include the most serious crimes known to man. Few cases involve crimes as serious as those in *Weston,* however. In *Brandon,* the Sixth Circuit noted the government's reduced interest in trying a defendant accused of lesser crimes. 158 F.3d at 947. Ralph Brandon was charged with sending a threatening communication through the mail. The Sixth Circuit stated "[w]e find it difficult to imagine . . . that the government's interest in prosecuting the charge of sending a threatening letter through the mail could be considered a compelling justification to forcibly medicate Brandon." *Id.* at 961; *cf. Bee v. Greaves,* 744 F.2d 1387, 1395 (10th

Cir.1984) (questioning whether the state's interest in trying suspects could ever outweigh a criminal defendant's interest in avoiding forcible medication with antipsychotic drugs). *Brandon* also noted the maximum penalty the defendant faced for sending a threatening communication – five years imprisonment. 158 F.3d at 961.

Weston and *Brandon* teach us that the forcible administration of antipsychotic medication may be warranted when the government seeks to prosecute incontestably serious crimes, but not when it seeks to prosecute crimes less so. Cases involving crimes of intermediate severity may present vexing questions, but Dr. Sell's case poses no such challenge. The crimes with which he has been charged are comparable to those in *Brandon* and thoroughly distinct from those in *Weston*. Dr. Sell is charged with making false representations in connection with the payment of health care services, 18 U.S.C. § 1035(a)(2), and money laundering, 18 U.S.C. § 1957(a). The maximum penalty for these charges is five and ten years imprisonment, respectively. He cannot be put to death nor imprisoned for life if convicted of these crimes, as was the case in *Weston*. He is charged with crimes which are far less serious than the violent, heinous and deadly crimes with which Weston was charged. Indeed, they are nonviolent and purely economic. There is no identifiable victim for these types of crimes; rather, only society's interest is harmed.

The majority deems the charges serious in part because of the number of counts Dr. Sell faces (63). At first blush, the sixty-two counts of fraud and the single count of money laundering might appear to make the charges seem more serious, but the sheer number is an inaccurate yardstick for measuring the severity of his alleged offenses. He

will be sentenced under the United States Sentencing Guidelines, which direct his sentence to be determined by the total dollar value of the fraud, *not* the number of counts. *See* U.S. Sentencing Guidelines Manual (U.S.S.G.) ch. 3 pt. D & §§ 5G1.2, 2B1.1, 2S1.1 (2001). An overly generous estimation of Dr. Sell's alleged illegal activity would place the value of his fraud within the range of $400,000 to $1,000,000. Applying this estimate, his base offense level would be 20 and (assuming he has no prior criminal history) his sentencing range would be 33-41 months. *See* U.S.S.G. § 2B1.1. This sentencing range demonstrates the charges against him are not serious enough to justify forcible medication. *Ante* at 568 ("Not all charges, however, are sufficient to justify forcible medication of a defendant; rather, the charges must be serious"). In any event – setting aside the Guideline estimations altogether – Dr. Sell's potential sentence is far more proportional to the maximum five year sentence in *Brandon* than to the maximum life-in-prison and death sentences in *Weston*.

The majority states Dr. Sell does not deny the severity of the fraud and money laundering charges. *Ante* at 568. This representation is wrenched from its context, however. While he does not deny the severity of these charges in the abstract, he certainly does not concede they are serious enough to warrant forced medication. In fact, Dr. Sell devotes most of his efforts to defending and minimizing the charges of conspiring to murder an FBI agent and witness, not to discussing the fraud and money laundering charges.

More telling still, neither the government nor the district court believe the fraud and money laundering charges *alone* support the forcible administration of

medication. The government all but dismisses these counts when arguing about the severity of the charges against him. The government focuses its attention almost entirely on the charges related to the conspiracy to murder the FBI agent and witness. Neither in its brief, nor during oral argument, has the government claimed the fraud and money laundering charges by themselves are serious enough to warrant forced medication. Likewise, the district court acknowledged the conspiracy to commit murder charges tipped the balance in its conclusion that Dr. Sell's alleged offenses were serious enough to warrant the forcible administration of antipsychotic drugs.

Although the majority properly omits the charges of conspiracy to commit murder from its analysis, *ante* at 568 n. 8, the majority inexplicably turns a blind eye to the apparent agreement of all parties that the fraud and money laundering charges alone are insufficiently serious to warrant forcible medication. This course of action is questioned.

This is not meant to suggest the crimes with which Dr. Sell has been charged should not be prosecuted. They will and should be. However, this defendant should not be forced to take antipsychotic drugs in order to be prosecuted for them. The government's interest in forcibly medicating an accused murderer may be essential, but its interest in forcibly medicating an accused thief is not. In my view, these charges are not serious enough to warrant the forced medication of the defendant, who, we must not forget, is a non-dangerous pre-trial detainee cloaked with the presumption of innocence. As a result, the government

has failed to satisfy the first part of the majority's three-part test.

* * *

The government is not without recourse upon a finding that the charges against Dr. Sell are insufficiently serious to warrant forcible medication. He will not be set free. A civil commitment is in order for him until he becomes competent, or voluntarily agrees to take medication. *See Riggins,* 504 U.S. at 145 (Kennedy, J., concurring) (stating that if the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment). The government asserts that its interest in punishing crime will be diminished by the option of civil commitment. It is true Dr. Sell's criminality will not be adjudicated as the civil commitment unfurls. However, the government's interest in forcing him to stand trial on charges that may result in such limited punishment does not outweigh his substantial rights under the First, Fifth and Sixth Amendments. *See Brandon,* 158 F.3d at 956-61 (enumerating an individual's rights in refusing antipsychotic medication).

I respectfully dissent.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 01-1862

United States of America,

Appellee,

vs.

Charles Thomas Sell,

Appellant

Association of American Physicians & Surgeons, Inc., et al.,

Amici on Behalf of Appellant.

Order Denying Petition for Rehearing and for Rehearing En Banc

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

Judges Loken, Murphy, Bye, and Riley would grant the petition for rehearing en banc.

Judge McMillian took no part in the consideration of this case.

(5128-010199)

May 7, 2002

Order Entered at the Direction of the Court:

/s/ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

(*CORRECTED* ORDER LIST: 537 U.S.)

MONDAY, NOVEMBER 4, 2002

CERTIORARI GRANTED

02-5664 SELL, CHARLES T. V. UNITED STATES

The motion of petitioner for leave to proceed *in forma pauperis* is granted. The motion of Law Office of Julie Ruiz-Sierra for leave to file a brief as *amicus curiae* is denied. The petition for a writ of certiorari is granted limited to the following question: Whether the Court of Appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments.